Meaningful Use Workgroup
Draft Transcript
April 5, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the HIT Policy Committee's Meaningful Use Workgroup. Just a reminder, this is a Federal Advisory Committee, which means there will be opportunity at the end of the meeting for the public to make comment. During the course of the meeting, only workgroup members are allowed to speak. Also, there will be a transcript made available of the meeting on the ONC Website. Finally, workgroup members please remember to identify yourselves when speaking for attribution.

We'll go around the table now and introduce members sitting here beginning on my left with Josh Seidman.

Josh Seidman – ONC
Josh Seidman, ONC.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Charlene Underwood, Siemens.

Marty Fattig – Nemaha County Hospital – CEO
Marty Fattig, Nemaha County Hospital; Auburn, Nebraska.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Art Davidson, Denver Public Health, Denver Health.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Paul Tang, Palo Alto Medical Foundation.

Deven McGraw – Center for Democracy & Technology – Director
Deven McGraw, the Center for Democracy & Technology.

Judy Murphy – Aurora Health Care – Vice President of Applications
Judy Murphy, Aurora Health Care.

Judy Sparrow – Office of the National Coordinator – Executive Director
We have a number of members on the telephone this morning. Neil Calman, are you there?

Neil Calman – Institute for Family Health – President & Cofounder
I am, and I'll be joining you probably in about 45 minutes in person.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great, thank you. Michael Barr, are you there?

Michael Barr – American College of Physicians – Vice President, PA&I
I am, and I'll be here for a couple of hours before I have to leave for a meeting.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. We have a number of members late coming in because of the weather here in Washington. Jim Figge, are you on the line?

Jim Figge – NY State DoH – Medical Director
I'm on the line. I'll be in, in about 45 minutes.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak, are you there? I think George is there. Is anybody else on the line that I missed? Okay. With that, I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Welcome and thanks to all those who are making special efforts to get here amidst the weather. We had weather roll in basically in and out, it was traveling 60 or 80 miles per hour, so it was in Washington D.C. for 15 minutes, but it stopped all traffic I think on the east coast. So thanks for the folks who are coming in.

We'll just get started with a review of the plan and maybe some general guidance on how we can accomplish this amount of work, or attempt to accomplish this amount of work in a short period of time. We do have another call coming up on April 11th, but as you know that's just two days before the April 13th meeting so we'd like to get as much done as possible for today. We're going to start off basically going through in order of the categories starting with category 1, which is divided into two categories, the existing that's changed in threshold, and category 1B, which are the new things added to category one. We'll then do categories 2, 3, and 4. Category 5, which we didn't have a whole lot of changes from stage one we're going to postpone until our call on Monday. Then we'll wrap up with a discussion, a summary of what we've done today and make sure that we've also covered the timing question.

Now, the timing question will also cover on the way, let me just remind you of what we talked about on our last call, and that is because probably the major concern that people had. People were very supportive throughout the entire comments that we were on the right track. These are the right things to be considering, but the juxtaposition of when the final rule comes out versus when people would have to have either developed new functionality and implemented it just was really, really short, as short as three months for hospitals, for example. So we entertained a number of options just for discussion purposes and we may want to consider categorizing each of the objectives as we go through today so that we can see how things would line up in the end.

Those options were, one, leave it the same. It's a year of reporting and it starts in October 2012 for hospitals, and January of 2013 for EPs. The second option we talked about is instead of a one-year reporting period to be a 90 day reporting period like stage one, and the nice thing about that is it would automatically grant another nine months of time. A third option is to delay everything, i.e. stage two schedule currently to be in effect in 2013 and one could recommend delaying it to some period of time, let's just say for a person, 2014, delay it a year. Then fourth is sort of a compromise between the two. That is, to delay certain pieces and the certain pieces would be the new functionality versus the existing functionality where you change the thresholds. So along the way it would be helpful if we, as we ran into, let's say the new functionality, we could say hey, this is one of those things that could potentially be delayed from the 2013 start date, and then we'd just add them up in the end and see how that looks.

In order to facilitate our discussion it would be helpful if we focus on a number of things, so we'll try to focus especially on the policy questions, where folks have asked for us to clarify things, a lot of them are very legitimate. One, we didn't intend to fully specify our concepts at the time we put out our RFC, but clearly we'd have to be more specific as we put out our recommendations to ONC. Then there's even more specificity as it goes out towards NPRM. So we won't spend a whole lot of time clarifying things. We'll acknowledge which ones that the words didn't seem to capture our intent and we'll go off and write more specific language after our meeting today. That's one kind of table we put things on.

Another kind is we may need some future discussion where we may need to do a little bit more thinking about before we make a decision. That's another kind of thing we should not spend a whole lot of time on today. So that's another piece of the table. The third is whether we push to stage three, so some things may have been a bit aggressive and we were interested in people's thoughts as we put out the RFC, but it might be too early to think about it in stage two, so good idea but we'll push it to stage three.

A fourth area, and this has a lot to do with clarifications and standards related comments, are things that the Policy Committee makes recommendations about the policy issues and then the HIT Standards Committee works on which standards to adopt with a LOINC for lab and so on and so forth. Those are decisions that we'd move over to HIT Standards Committee. A fifth place is there may be highly specific cases, let's say, chemotherapy, where it primarily applies only to oncology. Again, we don't want to spend all of our time discussing how do we wordsmith it so that it captures oncologists well. That's something that can be done through the rule making process, I would think.

Then finally we talked about the timing issues. We could consider a couple, but just one is this delayed new functionality. Another is the menu approach. ONC, CMS used the menu approach in stage one. They had indicated that all of the current menu would turn into core, and I think we've adopted that philosophy, but it's possible to give some flexibility in our proposed stage two to make some of those menus. So we have a number of parameters but we'll try to keep it straight as we go forward. Does that sound like a good approach in terms of we'll try to work on the policy issues and make some decisions on those and a lot of the finer points we'll work on later off line.

Remember that we're trying to keep a bias towards outcomes orientation over structural criteria. That's something that we intended to do all along. The closer we get to stage three, the more we want that to be the case. Part of our discussion today will be discussing the response to our question about should we even have waivers for those with high performance. In other words, if you've already achieved good outcomes, should you be worrying a lot about all these process measures? Then our overriding principles will try to be parsimonious because everything that we add adds burden somewhere. We want to just make sure that we head people in the right direction towards improving outcomes, just as the National Quality Strategy talks about, but try to stay away from some of the things that may cause documentation burden for something that really happens just because people are achieving better outcomes. How does that sound like as a process? I know this is sort of drawn out, but we'll try to remind ourselves as we go.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, I'm just letting you know I'm on. That sounds excellent. I'll be there in a few minutes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great, thank you. Now, what we thought we would do as far as process here in terms of going through, one, I want to just thank again Josh and the team at ONC who really did a tremendous amount of work to put together all of those comments. Again, thank the public for putting together such very helpful comments and submitting them on time. Then the staff at ONC really went through all of them and summarized them in an extraordinarily helpful way. It was very easy to go through these things to hit the high points, and here we're not going to be reading each one of those comments. We've all read them prior to coming here, so we're not going to be re-articulating them, but we're going to highlight some of the ones that we need to discuss moving forward.

Each category has one or two folks that have taken a more detailed look at the comments and hopefully teed up either some key revisions based on the comments or some key options to discuss as a workgroup for us to come up with a position moving forward with a revision. For category 1 which is improved quality, safety and efficiency and reduced healthcare disparities category, George and I took the lead on the ones that are not involving new functionality. I think I'll go ahead and start while George is traveling on his way in, and so now we're looking at the large document that Josh put together with the blue colors on the side. It is titled "Final Comment Summary for All Objectives and Questions." Along the way Josh also put together a very nice summary document about for each objective, whether it is already included in the certification criteria. Remember, one of the things we were concerned about is if new functionality requires new certification requires new certification, that takes some lead time, so that was something we were going to consider as part of our timing discussion.

Maybe I'll start out with the first one in category 1, so the current final rule for stage one in CPOE, computer provider order entry, in stage one the final rule there was 30% of unique patients have at least

one medication in med lists using CPOE. And what we proposed for stage two is in addition to one medication to one-up the threshold to 60% of unique patients and also to add lab or radiology where applicable, noting that this means you have to enter it through the computer but it does not have to be transmitted electronically, so that decreases the requirement for an interface. In general, the commenters supported this and I'd say they basically asked if we'd consider a couple of things. One, is they liked both the thought of increasing the threshold from 30% to 60%. They also supported the lab and rad orders, but had a couple of suggestions, either to do one or the other, or to add the new lab rad as a menu.

So that's our first discussion point. The choices are keep it the same, which is to raise the threshold and add lab and rad as part of it; two is add one or the other, raise the threshold or add lab rad; and option three would be to raise the threshold for meds and add lab rad as a menu. I'll open it for discussion. Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
Sure. Here's where I'm thinking we should also consider if there's a difference between inpatient and ambulatory. I think in the inpatient setting doing CPOE in a mixed workflow, where some is on paper and some is in the computer, is actually quite dangerous, the workflow around that. So to add in the lab and rad to me would not be a burden, because when you're doing it it's just as easy to do it for all of them. In the ambulatory setting, I think that's where it gets a little tougher, in that the connectivity that you might have for the radiology orders or lab is significantly different and I think the products that are used are less mature than they are for ePrescribing, for example, for medications. So I don't know if we want to consider another option, Paul, where we would actually potentially break out ambulatory from inpatient and not have the same criteria for both.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's an excellent comment. Most of the concern arose because, especially with the EPs, around the interface, because especially the smaller practices have to interface with potentially multiple labs and a separate radiology. Other comments?

Michael Barr – American College of Physicians – Vice President, PA&I
I would agree with the last comment ... I'd simply add ambulatory ... hospital to the recent site, so just indicate some agreement and support.

Marty Fattig – Nemaha County Hospital – CEO
I agree with Judy. Once you've started entering orders electronically, it's not a problem to continue and to use lab. My concern comes in how we're going to measure that, how we're going to come up with a denominator so that we can say, yes, they are entering this number of orders electronically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And with that measurement question on the inpatient side, yes.

W
How do we know ...?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If you have a patient with a medication, then 30% of those patients should have a CPOE entered medication. Similarly, for lab or rad, if there is an order in one of those categories then 60% of those patients would have something entered through CPOE.

M
So it would ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. I think you still can do it based on claims, if nothing else, or results.

Jim Figge – NY State DoH – Medical Director

Paul, I don't know if you can hear me. Speaking from the perspective of a Medicaid agency where we would actually have to audit this, this is going to be very difficult to audit unless we make it more generic. For example, if a specialist is seeing a patient and there are already meds on that patient's list, does the specialist, himself or herself, have to be the one that puts the order in? Or does it count if somebody else put it in? All those issues need to be considered when you start thinking how you're going to audit this. So I think we have to be more precise in what we're actually trying to measure here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, that was another question I was teeing up from the comments, and that's the whole somebody else entering. The way we've handled it in stage one, and I think it's still valid, is we said it could be entered by a license professional. The history of how we got there is we wanted somebody to have the knowledge to be able to act on any decision support feedback that came as a result of answering that order. So that would mean that a nurse following nurse protocols could enter it, because they're already eligible by that stage, presumably that's what the nurse protocol means. Verbal orders to someone who is not licensed would not qualify, but any other person who is licensed and can take the responsibility for acting or passing on that feedback is where we were with stage one, and that would hold true in stage two.

Jim Figge – NY State DoH – Medical Director
Paul, in order to automate this—because I'm telling you that the state Medicaid agencies will need all of these automated in order to make this doable. Are we just going to look at what exists in the EHR and report off of that without trying to track verbal orders and written orders and everything else, because if you do that it's going to be impossible for any state to audit it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In the EHR there is an audit trail that says who physically entered in that order. That person would show up in the user directory for that EHR and would have their credentials to say whether they were licensed or not.

Jim Figge – NY State DoH – Medical Director
But when we say patients who have at least one such order, some of the orders could be verbal and you would not know that because it's not tracked on the system. Do we want to be more specific about where the orders are so that they can be automatically tracked? Because I think we have to eliminate anything that you can't report automatically, because it just will not be doable for the states.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me see if I can understand your question. Even verbal orders are entered by somebody into the EHR with an audit trail.

Jim Figge – NY State DoH – Medical Director
Not necessarily. A verbal order could be implemented immediately. It doesn't have to be entered into the system. I think we need to clarify that these are the orders that were entered into the system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A verbal order, in order to be carried out in an EHR system, has to be entered somewhere by someone, and we're saying to count on the numerator that someone has to be a licensed professional.

Jim Figge – NY State DoH – Medical Director
Okay, but I think we need to explicitly say that we're talking about orders that are entered in the system. That's the only way that we can automatically track them, and that will eliminate confusion among auditors about which orders actually count.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that's one of the things we can put on our clarification list, and we'll make sure that's spelled out more precisely.

Jim Figge – NY State DoH – Medical Director
Okay, that's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me suggest a compromise to what Judy's—or accommodate what Judy and Marty said, and what if we left it the same for the inpatient side. That is, it would be 60% for meds, lab and rad, and for ambulatory because it really is going to depend on the practice, the whole depend on the practice clause might be a good place to use the menu option. So for ambulatory if it worked out for them they could choose that option. How does that sound? I'm getting some nods around the table.

Christine Bechtel – National Partnership for Women & Families – VP
... and also Neil Calman talking about how if he doesn't have the orders in the system everything hangs off of that in the ambulatory setting. So how would this impact the ability to use other functions in the EHR?

M
Say that again.

Christine Bechtel – National Partnership for Women & Families – VP
Neil has—

Neil Calman – Institute for Family Health – President & Cofounder
I'm here. Basically this is where you're getting your reporting and things like that, where you're doing recalls for people who happen to have mammograms, you're doing a lot of preventive services and outreach based on reports and things like that, that people are getting out of the system. So if we're not really requiring that if you transmitted electronically I don't understand why we can't expect both types of orders, both lab and radiology to be input.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. So let me see if I understand what you're saying. For those who are going to run reports and reach out in terms of managing, let's say, preventive services, they're going to need this in the system. Neil, that's obviously one of the measures they could choose, let's talk about EPs, so they have to choose three quality measures that may or may not include some of these preventive measures.

Neil Calman – Institute for Family Health – President & Cofounder
I'm not really just limiting us to meaningful use at this point, and I know that that's what we're talking about. But what you're trying to do is build a database of information that people don't really know what they're going to use unless we, the people who have experience with this, call this stuff out. The biggest regret that I've heard from people who are implementing systems is that they didn't enter all of this stuff in the beginning in real time, because it haunts you forever. If you don't put information in about radiology stuff, it's not like you can go back through paper medical records and retrieve all of the mammograms that have been ordered at some point if you're trying to do some sort of work. So I think it's important that we get people entering the orders early on, because that's the real foundation for almost all of the other work that's going to come in terms of people looking at their populations and doing quality improvements.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
= Was there more difficulty do you think on the hospital side or on the ambulatory side under the provision that you don't have to send them electronically, just entering them? I thought there was more pressure on the hospital side than the ambulatory side about adding orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, we had three people here at the table say that it was going to be fairly straightforward and since they have to do this anyway it is much more painful to be in a hybrid situation than to capture all the orders. The concern I think that was raised and raised in the comments, are on the EP side, particularly in the smaller practices where they have to reach out to non-owned ancillary departments.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
They don't have to reach out to anybody because they just need to enter the data. There's nothing about sending it anywhere.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's true.

M
Really, what we did before, we don't have any radiology interface yet because we used radiology groups all over the city depending upon our practice location, but every radiology order is entered in and then the radiology requisition was printed. So that's a fairly simple process, but it captures all of the orders and it gives you a place to scan results back to so that the results are then linked up with the order. So I think this is a really important piece. I wouldn't want to get in on this too quickly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right, that's a fair point. You're absolutely right. We've even spelled it out that the order does not have to be transmitted electronically and we can be even more explicit in the clarification. How many are in favor of that?

W
Yes, I would be supportive of that, ... automatically going to the connectivity.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, absolutely. Marty is nodding as well. Let's see if we have consensus.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, can you just repeat what we're voting on?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I certainly will, Michael. The current consensus seems to be that we would leave the CPO objectives as is. In other words, we're raising it from 30% to 60%, the threshold, and also including lab and rad orders. In other words, a patient who has a medication on their list, 60% of those patients should have a CPOE order. A patient who had either a radiology or lab order in the reporting period, 60% of those people should have had a CPOE entered order.

Michael Barr – American College of Physicians – Vice President, PA&I
So the first—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now the— I'm sorry, go ahead, Michael.

Michael Barr – American College of Physicians – Vice President, PA&I
I don't know if you were finished. I apologize. Go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was going to say we're back to the denominator issue. How do you capture the ones that were not entered through the system?

Michael Barr – American College of Physicians – Vice President, PA&I
Right, and see that—

M
We don't need to, because the denominator is the number of patients, the numerator is the number of orders entered into the system, and we don't care about how many weren't entered.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, got it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Just to add a consideration as we think about numerator and denominator, especially when it comes to ordering and systems, I know there's some work being done by some of the committees to look at HIT sensitive measures that systems generate. Again, this can be a space where the systems actually count the number of orders as long as there's a standard. Again, I don't know if you have a time that's set in terms of how we do that cancellation. Our systems today do that kind of counting, but I'm sure we don't do it the same as some other vendor systems. So we can actually get to where we do accurate counts. Now the gap there certainly is you're not going to know what's not ordered in the system. But we start to move away from this approximation of orders to actually counting the real numbers of orders in systems, so that can be a consideration as we start to look at measurement too in the process, if we authorize coming up with a standard of how we might want to count CPOE orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a fair point. It's easier to measure folks with meds on a med list, because those are static. It's harder to capture the other unless we do what Charlene talked about, which is there are orders in the system, there certainly are claims for them we can figure out. I think we may need some help in being more precise in what we set for this objective and maybe a small group including you, Charlene, can help work on that. So that's another one of our clarifications.

Jim Figge – NY State DoH – Medical Director
Paul, can I just make another comment on the denominator? I think this is a circular thing, because it never gets into the system you don't know that it was ever done and you can't count it. I think going to a standard where you say that there should be at least a countable number of this type of order, a countable number of that type of order makes more sense, because the percentage is a circular logic. You're never going to be able to precisely calculate it because you don't know what wasn't entered into the system.

Neil Calman – Institute for Family Health – President & Cofounder
I think that's an interesting idea. So the way this would read then—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... for medication orders we have the medication list, for lab orders we have the laboratory input, but for radiology orders we're kind of stuck.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're chuckling because George just walked in out of the rain and walked up to a microphone and continued the discussion. The way I understood Jim's suggestion to be, is it reasonable to assume that 60% of your unique patients in your database, let's say we also define active patients, so let's take that a little bit later, they should have had a lab or a rad order. Can we just say that?

Neil Calman – Institute for Family Health – President & Cofounder
I don't think we can say that 60%, because it's going to depend upon somebody's practice. Surely 60% of pediatric patients are not going to have a radiology order, and probably not even 60% of my patients, but let me say that I don't think that threshold for this is so important because once you set this up in the system everything goes through the same way. You're not going to set up a system where you put radiology orders in the system and they print out and then have people not use it. I don't think we need to maintain such a high threshold. We want to make sure that the system is set up to do this and then I think it becomes pretty standard that people are just going to use it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Would you suggest 30% or even lower?

Neil Calman – Institute for Family Health – President & Cofounder

I think 30% is probably reasonable. Again, though, if you end up with somebody who doesn't use a lot of radiology procedures you don't want them to sell meaningful use over not ordering enough radiology tests. That would be—

M
It would be a little—

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, can I make a suggestion? It sounds like there's great consensus around the CPOE for medications, but we're having a lot of discussion about the lab and rad. Would it be reasonable to make these into two separate categories? So deal with the CPOE for medications and escalate the threshold, as has been prescribed, the recommended, and do what Neil suggested in a separate objective for the lab and rad and lower the threshold. Because I agree with him, if people set it up they're going to do, and I agree with his comment that once you do it you realize the value of it in terms of the quality improvement, but it is a new objective and there are some variations in how people will be able to do this. I think we can go with the consensus on the medications and raise the threshold, as has been recommended, but separate out the CPOE for rad and lab and do a lower threshold.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That sounds very reasonable. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I might suggest that what we do is, kind of going along with that, so medication we're okay on. If we can define a reasonable denominator then we go with it. So for laboratory, which I think we will be able to because we're also in a different objective specifying that, and if we can't, say in the case of radiology, because we're not mandating radiology reports come in, we do it by attestation. So we can attest that we're doing orders and not measure anything so we get it pushed forward but we don't put the reporting burden on either side. Then for lab, if we can define it the way we define medication then we just have to decide do we start with 30 at this juncture or 60 for lab.

M
I like that.

Michael Barr – American College of Physicians – Vice President, PA&I
I like that idea.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, one, let's accept Michael's idea of separating it. I think we can easily pass the medication rate of 60%. In fact, let's go ahead and do that. All in favor?

W
Yes.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then, any opposed? Okay. So that puts that to rest. Second, for lab and rad, you know what, as we talk about this I wonder if we should just make it all procedures, and here's the reason. That covers pediatrics, because they all have immunization, so what we're trying to do is expand CPOE, there's no reason to limit it to lab and rad. Partly the reason we did lab and rad limitation was because we were worried about how do you set it at a reasonable threshold. If the idea is that we're just getting them to expand CPOE there's no reason we should limit it. Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
A comment on that, I don't think this should be a barrier. But a barrier could be that systems today are certified on lab, rad and meds, this is the three that they're certified on, so that was part of the process where we recommended them. I'm not opposed to going to other orders, because most systems do today have those capabilities. So it's not a barrier I don't think of development, but it may be a barrier with the certification process.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. Okay, so recognizing that and so that we wouldn't have to change certification, do we want to set some low threshold or follow George's suggestion of just having attestation?

M
I'm fine with attestation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the attestation would be that CPOE of lab or rad orders is in use.

W
I thought we were doing that as ... for radiology.

M
No, just radiology.

W
... for labs too?

M
No, just radiology. I thought that the recommendation was we're separating them and that the attestation would be for radiology.

W
Right, that's what I heard as well, simply because you'll have, I think, more patients who will have a lot more labs than you will radiology. There's also a separate criterion around that, and so it might make sense to not have it be attestation but have it be more akin to medications, although the threshold is debatable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So was your intent just radiology and have labs follow a threshold, George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Labs follow a threshold unless in further thought we can't come up with a reasonable denominator, in which case we would pull that one to attestation. In other words, if we can do a reasonable denominator then we can go ahead and maybe pick a 30% on lab if we can do it reasonably, otherwise attestation.

Jim Figge – NY State DoH – Medical Director
I just want to point out in the Medicaid program we have other kinds of providers like dentists who readily order labs, so we have to keep in mind that we're talking about many different types of clinicians and if you set an arbitrary denominator, it's not going to work for some of those groups.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's not an arbitrary denominator. It's the number of patients who have structured lab results.

Jim Figge – NY State DoH – Medical Director
If you're saying that's 30% of your patients in your EHR need to have structured lab results, it may be that you can't reach that 30% number because you don't order labs.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Thirty percent of patients who happen to have structured lab results need to have an order.

Jim Figge – NY State DoH – Medical Director
But that's a different thing to audit. Then you're looking to see whether there are lab results in the system, not whether there are orders for lab results.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, exactly.

Jim Figge – NY State DoH – Medical Director
So be very clear what you're actually looking for because that's what auditors are going to need to know, what is the exact thing you're looking for?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So it's analogous to the medication criteria, Jim. We're looking for folks who have had something. We're looking for folks who have a medication on their list. And in this case we're looking for someone who's had a lab resulted.

Christine Bechtel – National Partnership for Women & Families – VP
But I guess if that was the case, it's Christine, wouldn't we want a higher threshold than 30% for labs?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We could.

Christine Bechtel – National Partnership for Women & Families – VP
I was thinking that the denominator, like Jim, I was thinking the denominator was all patients. If you have structured lab results, you've got to have more than 30% ordered electronically, I think.

Jim Figge – NY State DoH – Medical Director
Either way. I was just trying to track our previous, going ... the same timeline. I'm okay either way.

Michael Barr – American College of Physicians – Vice President, PA&I
I think the issue here, Christine, is it's a workflow issue, because these are not going to be transmitted electronically so it's not required to be transmitted electronically. Doctors and their office staff are going to have to complete paperwork forms to send it out to the labs in addition to entering it into the computers to ... reorder because they're not going anywhere. So an understanding of the dual workflow setting a high threshold means a lot of extra work for practices. So I think it's very reasonable if you set a lower threshold to start with. When and if it becomes required to transmit it electronically, then I think all the workflow goes through the emergency ... electronic health record and it becomes more reasonable to set a higher threshold.

M
Are we saying that the standard is that we're looking for all patients in the record that have structured labs or all patients that have any labs? Because oftentimes the labs will come back on paper and they get scanned in, which is going to be hard to quantitate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think there's a sentiment around the room that says we would like to move on this issue of getting other than meds through CPOE. So we'll have a small group work on how to specify this primarily, to one, measure that there's forward progress, but two, not have a high burden. So we'll go between these various things that we've discussed. Is that acceptable to folks? But we would like to have an expanded CPOE objective for stage two.

W

I think we should look at the measurement criteria for stage one because my recollection of it is that we were looking at unique patients that have a visit in that year, it wasn't all patients in the database. I was just going to try to look that up. But I like the idea of let's have a sub-group look at that. I'm not sure we want to change the measurement criteria away from the way we're measuring it in stage one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. All of these are acknowledging that once you have the implementation workflow in process it's not going to be like you want to only do the bare minimum. It's in nobody's best interest. So we're just trying to find a way to give people credit for having begun that journey.

Neil Calman – Institute for Family Health – President & Cofounder
Paul, just one more thing, Charlene called out the issue about certification. Should we call out now that for stage three that the certification group's got to start working now on making sure that systems are certified to accept all orders electronically by stage three?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think we're under that time crunch to be talking about stage three. I'm not sure how we do that either, to tell you the truth. I think the important piece here is the systems in place that are certified for stage one would be capable of enabling the providers to do stage two the way we've defined it so far.

Neil Calman – Institute for Family Health – President & Cofounder
I was just saying that since Charlene was saying that we can't move ahead with calling out orders, I'm thinking if we're sitting here a year from now talking about stage three and the systems haven't been certified for all orders then, we're going to be in the same position, right? At some point, we need to call out that we're going to expect all orders to be entered electronically, I would imagine by stage three, and so I guess we'll just park this issue. But we should make sure that that gets put on the table for the certification ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's a fair point. We don't want to be in a Catch-22 and have this same thing happen to us two years from now. But we'll figure out a way to do that. Okay, just a couple of small points that came up in the comments that I think we can agree on. One, the question is, do echo and ultrasound and anatomic path count? I would guess yes. Is that clear for people? Okay. Then we answered the question about verbal orders.

Okay, let's move on to the second one, do you want to ping-pong or—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Sure. The next one is drug-drug and drug allergy interaction checks. Remember we said we employed drug-drug interaction checking with appropriate evidence-based interactions. The main concern that you'd guess is well, which interactions should we use, how many do we need to have, and how do we prove that they're evidence based? This is in the context in which we just had a presentation from ONC and the RAND Corporation detailing their work and so we may have some ideas there. Then also other kinds of questions like definitions, like what do you mean by employee or activate, and also how are you going to measure compliance. I think those are the main issues on this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let's remind ourselves that we had the presentation and RAND called out some high utility alerts, meaning high impact in almost never events, but they form less than one percent of all the alerts. So the big opportunity is in not the never events, and so another approach they had was to look for things that have a very high false positive, i.e. a low utility lift. So where we left off, I think, is there a list that can be produced that is low utility and is endorsed and maintained by someone, that someone could be HHS, so that people would feel free, from a legal liability point of view, to turn off those alerts. With thinking about the overall net positive, that is, if you're bothered less by false positives it's more likely that you will pay attention to the others, and that's certainly been the experience that's written up by David Bates' group at Partners.

So the work that remains to be done, and there is continued work on this, is to come up with a list that we could recommend that people turn off in order to have a higher positive predictive value of alerts that do get revealed. Unfortunately, I think there's some work going on, and if that comes to fruition before we make our final recommendation in June then we can incorporate that. But that's the thought we had here, is the notion of calling out evidence based drug-drug interactions is to try to improve the positive predictive value to reduce the false positives.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
My comment on that is i want to separate what Randy's doing, which is trying to help the field, versus what we're doing which is kind of certifying meaningful use. It's possible that we could get by with saying, listen, for the purposes of proving you're doing meaningful use you just do that RAND high, what do they call it, high something?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
High utility.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
High utility DDI, and that gives you the meaningful use. Then whatever you want to do from the middle group is your decision. But that qualifies you for meaningful use because before we just had an attestation that you were doing something. So the bare minimum something is the high utility .... This is going to be 18 months from, it's a while until 2013, so it's two years from now they should be done with that. So I was thinking that for the meaningful use metric instead of telling them what to shut off, because we're trying to measure some positive movement, just do the high utility one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, Neil Calman just arrived.

W
He wants to make a comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other comments on George's? I think the question that's being teed up is do we propose for meaningful use criteria that it is a must enable, meaning have turned on and then used in their system the RAND high utility alerts, or do we take the approach of looking at turning off the low utility alerts?

Jim Figge – NY State DoH – Medical Director
I favor the approach of having minimal requirements and then the provider can use whatever else they want to in their own discretion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Others?

Marty Fattig – Nemaha County Hospital – CEO
In our organization that's what we've done for a number of years. We use the Micromedex list and the doctors, all the providers actually have the alerts as they feel that they need to be. So I think the main goal here for me would be to not be too prescriptive, because different providers differ in what they would like to see.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I think the work that would remain here is that we would be a bit more precise in what we mean by evidence-based alerts.

W
In which many of the products today, Micromedex, the ones that are embedded and used in products, are by definition evidence-based. So when you say evidence-based, people say they are evidence-based.

We call into question why even say evidence-based if it's already evidence-based, because that's the tools that we're using.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And there's nothing wrong with them already using an evidence-based database.

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

W
So it's just how we get through that definition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. We can, essentially in our description or preamble talk about what we were thinking about in terms of improving upon the false positive issue and point to work, let's say. Those are some of the ways we can help people understand why we bother having that phrase in there, because we recognize this problem of false positives and there's work going on, and that's what we'd like people to take into account, that kind of a language. Does that make sense?

M
I think that if we're going with the attestation that I'm doing something, then maybe evidence-based doesn't have that much. If they're deciding they're deciding. If we have evidence-based, then you can say, okay, we know what RAND did, and if we're doing those then we're doing those and we know they're evidence-based. If we're not doing RAND, then I don't know if we need the phrase. I think the phrase goes in the preamble but not in the objective maybe.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. How do people feel about that?

M
Or we need the definition, like we should be measuring it. If we're going to put the phrase in there we have to measure it and we have to tell them how they're going to measure whether they're evidence-based. So then it becomes simply pulling stage one to stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. There was a question on enable versus employ. Enable means—

M
Oh, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... there. Employ means you have it in use.

M
What was enable? Don't answer that question. We will clarify. I thought that we were employing in stage one, but—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're right.

M
But they do ask for the definition of employ, so it means produce alerts on all electronic orders. Maybe we need to actually ..., so we'll do that.

M
I'll answer that question of enable versus employ, if there is any difference.

Judy Murphy – Aurora Health Care – Vice President of Applications
I do believe stage one just said that you have to have a system that's capable of doing it and it was a yes/no criteria. So it probably is a good point. It didn't have to be turned on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. The way this certification criteria was written, you could have it in the system but not actually turn it on.

M
Do we have attestation? Because one of the questions is are we attesting that we're using it, or are we reporting a compliance rate?

M
Not checking the level of compliance, but what do you want back? If you report a compliance rate then you know it's getting used.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Or, you can even employ that these things fired.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so we'll work on what we intend is that the certification reflects that they are turned on and available to the user. One way that you can measure that is do these things fire. We're not at a point actually in our science to understand what is an appropriate compliance rate. In other words, the user took an action that was consistent with the alert that was shown. So that's our current state of knowledge. Okay, so we are looking for it to be turned on and firing in front of the user.

W
One other just forward-thinking comment, in terms of trying to, this utility rate ..., one of the implementation methodologies that seems to work is when you're doing an alert there's a feedback loop. The providers did the alert and the feedback loop, you measure is it being used. But also when you bring up a new alert there's a feedback loop and there's feedback by the providers that say this works ... or whatever and then it fine-tunes and actually makes it work for the institution. That kind of thought process where we start, and I think we had that in there at one point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... going into the ....

W
But a feedback loop that says this works or causes too much noise and all that type of thing is helpful in tuning and implementing systems.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. Are we ready to move on then? Okay, the next one is ePrescribing, and we currently have for EPs 40% of all the permissible prescriptions are transmitted electronically. Our proposal is 50% of orders are transmitted electronically, i.e. not faxed, and we're now including hospital discharge. So the comment is that because hospital discharge would be new functionality, there is a request to lower the threshold from 50%. As far as certification, the ambulatory EHRs are currently being certified for eRx, obviously we're just raising the threshold. It would be new functionality for inpatient EHRs. Comments on this in

terms of, one, adding the threshold and adding the functionality to hospital discharge; and two, lowering the threshold? Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I think the hospital discharge thing is difficult. Very often people don't know the name of their pharmacy and stuff like that when you're trying to get it, and so I don't know if that's been everybody's experience, but it's really been ours. You say, where do you want the medication sent? And unless they have a bottle or something in front of them to look at, they really don't know the name of the pharmacy. I would imagine somebody on discharge, you really wouldn't know where to direct the medication a lot of the time, so I would suggest that we keep that threshold low but keep it in, because we want people to have the functionality for people that do want their prescriptions electronically. But I think that there's going to be a lot of times where it's just not going to be possible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point.

Marty Fattig – Nemaha County Hospital – CEO
I agree with Neil. That would be our consensus from our hospital perspective. In fact, there are some patients who come in for our services that have had no prescriptions in the past, so, who's your pharmacy? I don't know. I don't have one yet. So we really need to accommodate those folks. There's another piece to this too, which is that people don't often know how to reconcile their discharge medications against the stuff that they have at home. So if you just send it to the pharmacy you're sending prescriptions for a lot of things that people have adequate supplies of at home already because they're not all new medications. And so there really needs to be more of a process here and discussion. So again I think we should do it, but keep the threshold low.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good points. Anyone make a suggestion for, this is again starting the journey and what's a decent enough threshold to make sure that it's started?

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, people suggested 40%. It actually almost sounds high based on some of these comments. I'll just throw out 20% as a starting point.

Neil Calman – Institute for Family Health – President & Cofounder
I'd be comfortable with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil's comfortable, George. Okay, so 20% is the way we write it. We would raise the ambulatory from 40% to 50%, we would have a new objective for hospital discharge only, and that would be set at 20%. Really, once you have any amount then you have that capability. But for the reasons that people discussed it's hard to get 50%. So is that fair? Okay. There was a question about fax, now recall faxing is only in those situations where pharmacies cannot accept it. It wasn't as an out for eRx. This is just a clarification on the comment.

Okay, ready to move on to demographics.

W
.... This may be a consideration, it was signaled earlier so the market was aware that ePrescribing for hospitals is going to be coming. So given that, however, it would have to be certified, and that's a barrier but it could also be considered as a menu item. So there are a couple of options in terms of that time frame that we can consider.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, demographics. We previously were recording demographics for more than 50% of unique patients and we suggested that we move to 80%, and we use them to produce stratified quality reports. The first question is the threshold, is 80% reasonable? There are questions about whether an ADT feed from their other system counts, or do they have to actually manually enter into the EHR, a point that we need standards, which goes over to the Standards Committee. Also what are we measuring? Are we just being able to produce reports? Are we measuring how many reports we produce? Also some comments that we have similar objectives here that are kind of overlapping in different ways. We have here producing stratified quality reports. Then we have the quality measures objective. Then we have the registry objective, which is later on. They're all somewhat interrelated, and so is this the right way to split it up. I think those are the major issues that people raised, I thought.

I think we originally put this in our objective in order to get EHRs to be certified to be able to incorporate this information. One of the comments that came up is I think we adopted the CDC recommendations and that was before the IOM came up with its studies, which were more granular. So I think we were originally planning to incorporate that in stage three. One question is should we move into stage two. Once you acquire this information it's much harder to go back and do the rework, so it's a combination of what granularity, and I think, as George mentioned, all of the what do you do with this information can be put off for quality measures and all of the other things you do, the patient lists, etc. But what we're trying to do is make sure that, one, the systems are capable of capturing it in standardized format; and two, that we have the workflow, the processes to capture this. That's what we're after in this objective. I don't think people had a problem with the 80%, it's what do we capture, and maybe we can talk a little bit about the IOM categories and what granular IOM categories. The other thing that came up was the mixed rate. I'm not sure what the IOM said about that.

W
The IOM did say you need to have locally defined flexibility basically. I think my question here, I have two comments. One is, at a high level when I think about the National Quality Strategy and the work that ACOs are going to be doing and otherwise, they need to be collecting this data and they need to do it now, because it is too hard to rework. So for performance purposes I think they're going to really need it, and I think my question is the law, HITECH actually has the Standards Committee, requires the Standards and the Policy Committee to define standards for race, ethnicity, language and gender. So I know that we did some early work on that, as you mentioned, Paul, but I'm wondering if the Standards Committee could prioritize this and do it very quickly based on the IOM report so that we can actually pull this into stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That couldn't go on our discuss with HIT Standards Committee, and specifically it's to capture the more granular data recommended by the IOM.

W
And I think we want to specifically flag for the Standards Committee the need to have a locally defined field, more than one even.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

W
This is the feedback from the broad vendor community. This is a big development effort and a big implementation effort. So if we do this one, this is one that will definitively impact the timeline. There are thousands of these.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that's on our list of column three, as I'm looking at the list that Josh put together, which is the not certified.

M
Can you just explain that a little bit so I understand it? That doesn't seem to me to be very difficult.

W
And too as you start to define, again, there are a lot of different categories of ethnicity that have to be broken down. So the data collection has to be built in such a way that you can easily capture and break down those data types. Those are not in systems today. These are registration systems that capture that. There are a lot of registration systems out there that collect this information. So those revisions would have to be made to the system, we'd have to be able to capture it, then we would have to roll that out across thousands of customers and providers and teach them how to use this new approach to capture this information. So it's a big development effort and it's also a big implementation effort. This comes from evidence in speaking with providers who have rolled out the changes in Massachusetts and the impact that that had in terms of when they did that across the provider community. This is a big one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'd second that. We had this state law that went in, and it's a major clinical operations change. It's not to say it's not technically difficult to program these things in the computer, but the whole line, which is from the development and it does go back to the reg system, then the EHR has to accept it, but the people process has to capture this information. And it's not an easy thing to teach, so it's just one of those things that will take time. Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
I'll echo Charlene's comment, because of what happens in a database conversion. We all bore that brunt in the smoking status because most of us did not include the value set that was incorporated into stage one for smoking. So you can start using the new one but then what do you do with all of the stuff already in your database and do you convert it, etc. There is a pretty big burden.

My second comment on this one is we're expected, as part of demographics, to also document cause of death, preliminary cause of death in a structured way, and there was no specified code set for that. So that's another thing it feels like we should take back to the Standards Committee. I know it wasn't called out specifically in the document from Josh, but it is in the original criteria, and I know that because many of us, again, were not documenting that in a ... way, so from an implementation standpoint, but it feels like we should get toward a standard for that.

W
This is .... should be deleted and you should just do final cause of death, because our customers are literally making it up at that point of entry. They should rethink that element.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, well give standards something to do.

M
To clarify, we are obviously from our discussion, because the question explicitly was does this include ADT feeds, and the answer is yes, because that's one thing we should just state.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we had to almost insist on this because if we're going to use this information it has to be an EHR. Okay, moving on. The clinical quality measures, this one actually is a query that is going to be directed to our Quality Measure Workgroup. It has a lot of good information here. I would guess one of the high points is the question which turned out to be, I think, question five and the notion of group practice. So this of course came out before the ACO NPRM and all the talk of ACO, but clearly the movement towards accountability at a larger scale, a larger enterprise, would speak to allowing group or maybe even encouraging group practice reporting. The comments came back as being overwhelmingly preferred as well. So I want to entertain some comments on just group practice at the moment. As you know, the statute talks about incentives are individually directed, so this is an issue. Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I think this is really an important transformational issue. We're moving the healthcare system to being more team based, more group based, not even just physicians anymore, and so if we start calling out quality measures that are physician based we're going to move everything backwards from that point. This is a huge challenge to figure out who the group is and what the dynamic is, but that doesn't mean we should retreat to a position that we're all trying to move away from, which is all of us seeing the patient as our individual patient and functioning that way. I think it's a challenge, but I think we have to deal with it. I think the practice environment, using a practice-based quality report is right.

Second of all, because that's the way workflows are established. The practice environment, if you look at cardiac outcome data in New York, the same surgeon practicing in three different hospitals will have three different outcomes. So there's proof out there that the setting determines a lot about somebody's quality, and I think that you ignore that if you just look at the provider or the physician and look at their quality outcomes. So I think we have to move in this direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You used the word "just." Is it okay to have both individual and group, because some of the comments talked about people "hiding out." You can have low performers and then still have group ....

W
I just need to clarify, because I think I'm conflating two things. One is the issue of an alternative way to achieve meaningful use, which is basically on quality measures instead of features and functions. The second is the group reporting option, and I guess I thought, and I must be clearly wrong, that the group reporting option was really about reporting meaningful use and not necessarily group level quality measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Question number five that you asked was related to this alternative pathway, and we put that in with the clinical quality measures objective. Question number six was about group reporting option, which is potentially for both. It's for both reporting the meaningful use functionality measures as well as the clinical quality measures. So just for discussion we're just talking about the group issue right this moment –

W
... clarifying, it's group reporting of both meaningful use percent of CPOE that we're using and clinical quality measurement reports. That's what I'm clarifying, and I'm hearing Josh say the options that they proposed is both, reporting both.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... proposed anything. But the question that was posed was about both, yes.

W
Right, so I think on the quality measurement side from a consumer perspective it's a challenge because when we look at how those measures get used in the end ideally including by consumers and purchasers, they need individual level data. Group practice data is not helpful. We know that. But I understand Neil's point about team-based care, so it may be that it's more relevant to have some team based quality measures that get reported at the group level. But I think the both idea is really necessary because it's not meaningful to consumers to have group practice level data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That was a concern expressed by the development community that measures today are written to be for the individual provider. So to make that transition to going to a group, we don't know how to do that yet because we don't have those measures that say what the group is and how we do that. So again that's some new development .... Then if we're talking about group development of meaningful use leaving

aside the quality measure reporting, I guess I'm struggling to understand how that would be operationalized. Because again you can have six docs and you've got three really high performers who are pulling along the other three, that doesn't feel to me like a good use of taxpayer dollars to be supporting the three who really aren't doing it, but the other guys are so good that they're making it happen. So I have some concerns about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's separate the two. One is going to be easy. The group quality measure reporting will actually go to the Quality Measures Workgroup. That's why that's easy. But it truly is right what Neil was saying and Christine, so it really almost has to be both, because they're going to want to know inside the organization as well. Now, let's move to the group qualification for meaningful use incentive and the latest on the floor is Christine saying, well, one, that's not even consistent with the statutes, but two, we are looking for each individual practitioner adopting and using this tool effectively. Other comments, let's say, to the contrary. It seems like there's a lot of head nodding. Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
I agree with what you just said, Paul, but the flip side of that is the patient centricity. And if we're doing the right thing for the patient irrespective of what team member executes on it, then it probably makes sense to look at the group rather than just the individual practitioner.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... capture that in the quality measure by group?

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is an incentive program to get all practitioners on this infrastructure so that we can change all—

Judy Murphy – Aurora Health Care – Vice President of Applications
And the idea of the hiding and—

Christine Bechtel – National Partnership for Women & Families – VP
Also, I'd just say, if we think about doing the right thing for patients that's exactly what I'm worried about, so that if you've got one provider in a group, and with my luck it's going to be my provider—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I hope you've changed your provider by now, Christine.

Christine Bechtel – National Partnership for Women & Families – VP
I'm still working on them. I'm such an optimist. But anyway, so it's going to be my doc who doesn't do portal access, and that's not meaningful to me or whatever. I guess I have concerns. But if somebody has an idea for what that would really look like I'm open to hearing it. I just can't get there from here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we have agreement on both things. Jim?

Jim Figge – NY State DoH – Medical Director
One comment, to follow up on what Neil said, I think it depends on what the definition of group is. If you're talking about team care, you might have, let me give you a specific example, taking care of a diabetic patient you might have a podiatrist, an endocrinologist, a primary care physician, and an optometrist. That could be the group and then the quality of care delivered to that patient is a function of how this whole group works together to take care of that patient. I think that's where you're going to get real value in this idea of group quality metrics. So that could be something that we send to the Quality Committee to think about how you would do that.

Christine Bechtel – National Partnership for Women & Families – VP
We might look at the ACO regs, for example, that just came out, which really basically you have to attribute a patient to a team of doctors. So the agency would be having to have a stroke at this point, but to understand how to create teams by an individual patient and then assess meaningful use on that team, I love that idea.

M
That's an area where you could also introduce HIE, because if these folks are in different practice locations you need communication and that's where you can get HIE involvement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think we have good agreement on those two pieces. Let's go to a tougher issue, which is essentially the waiver for high performance, and put aside for the moment the definition of high performance, but from a meaningful use point of view, policy point of view, we had talked about this before, do we think that in stage two versus stage three we should be moving towards some kind of a waiver situation where you don't have to qualify based on certain process measures and can get a buy based on high performance? Christine?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, ... talking. I think this is something that we need a lot more work on and really to think through, because I have a couple of concerns. In an ideal world, and we talked about this early on in the first year that we began to work on this, which is in an ideal world you'd have a core set of performance measures that just absolutely couldn't really be done well without using your IT in a meaningful way. So if you're hitting those measures you're good to go. It's parsimonious. It's elegant. And I think that in theory this is a nice idea.

My challenge that I'm seeing is, one, today's performance measures are not really well suited for that. They're often way too process-y or structural, and there's an enormous amount of pushback from a number of folks in the provider community around the kind of quality measures that are actually meaningful to patients, which is outcomes oriented and much more patient centered. So I feel like we have a dearth of quality measures that will get us there anyway, and so while in theory this is a nice idea, but it also— I again hear Neil Calman say, as he said in the past, I can improve my care for patients with diabetes using note cards and Excel spreadsheets. So why am I making this big investment and how do we really ensure the technology is being used. I like the idea in theory, but I again am really struggling to see, given today's data quality measurement, how we get there in practice. I think a sub-group to really work on what would this look like would be a good idea.

Then the last thing I'll raise is specialists, so we'd have to have, again, sort of back to this specialty specific performance measure set that links back to being HIT enabled and pull in all the right dimensions. So the thing that we suggested in our comments was to look at the idea that you don't just look at quality measures, but you base it on having ... meaningful user in stage one and in stage two, which would give you some guarantee that they've gotten used to using the functions over time. Then you can overlay a set of hopefully rigorous and good quality measures that Tom Tsang is working on, on top of that. So then really the out years become much more parsimonious, but it builds on having absolutely having to have been a meaningful user in stages one and two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's well stated. Let me contextualize that and the way you ended, which is the Quality Measurement group is really doing excellent work in this area. Although there's not going to be, as you suggested, a lot of good measures available in stage two, they have the same timing problem, the kinds of measures they're considering for stage three really are excellent and are very much more in tune with what the patients want. So I think I hear what you're saying is nice idea. I think we can revisit it in stage three, when that was our outcomes oriented stage anyway, because even if we wanted to we don't have the measures to prove somebody is hitting these outcomes in today's measures. There's a lot of head nodding. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't even see it as an alternative. We're trying to move everybody to outcomes, so it's not either you make your outcomes or—eventually it's just everyone is on the outcomes side. But I do think there's going to be some minimum common culture and infrastructure we want everyone to have. We want residents, when they move between institutions, to have a similar environment. We want a healthcare organization that delivers most of the care in a city, but there's a provider who's outside of there, they can get to the note. If that care institution achieves quality without doing the electronic orders, without doing electronic notes, without being electronic at all, then the provider is locked out of the patients that they see if they send them to the hospital. So there may be some bare minimum infrastructure that we want everyone to do even if it's already high quality. But I think the sentiment here that's expressed is we should be moving to outcomes, and that was our goal from the beginning.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. You summarized where we were last time, and I think it still holds. Shall we move on to promised meds and allergy ...?

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There we had 80% of unique patients with at least one entry in those three lists, including non-appropriate, and we were going to continue it in stage one. First of all, as far as acceptance it doesn't seem like there's a lot of fight against that level of threshold. There's a little bit of question whether we should go higher, so I'll put that aside and we can discuss that too. There are questions on definitions of up to date and current and active, and that's reflecting our stage three proposals, so that's a separate proposal. We purposely didn't put it in stage two and we're trying to drive up-to-dateness through using those data in other objectives. That's being outcomes based and is generally what we're trying to do here in general. Finally, there's a question on who's allowed to enter those data, and the idea is we want accurate data, and so however we can achieve that. Any questions or comments on this one?

M
So we'll leave this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we'll leave this, right. Record vital signs, we've shifted the threshold from 50% to 80% of unique patients having vital signs recorded. I'm in general agreement with that. A couple of suggestions/questions, one is the scope of practice issue, which is not every specialist may record blood pressure, let's say a dermatologist or a radiologist, for example. That's been an ongoing question. The other is how often, and some proposed even every visit for some of these. Some of these may apply to one specialty, ET, primary care versus another. Do we want to make any comments about the applicability essentially of these thresholds? Neil?

Neil Calman – Institute for Family Health – President & Cofounder
One question I had looking at this was about the definition of unique patients. Do we have a definition in terms of what the look back period is and what we're considering active patients?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Who knows in the certification criteria?

W
I don't have a full definition, but a unique patient that has an encounter during that measurement period, meaning that if the patient is seen more than once they're counted only once. That's, I believe, the core definition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so it's during the measurement period. Now, there's an interesting implication then when we think about reducing the measurement period from 12 months to 3 months. Hopefully that doesn't—

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm sorry?

W
We're doing that this time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We are doing that this time. But hopefully there's almost no implication in behavior.

M
No, that really wouldn't matter. We're basically saying if you need an encounter during those three months you have a chance to run the vital signs, so I think it's okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... behavior.

M
Yes.

M
... check vital signs, this might be an opportunity, again, for HIE, because they can import vital signs from the primary care.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What do we think about the specialists and scope of practice?

Judy Murphy – Aurora Health Care – Vice President of Applications
This is Judy again. The other one that's in there that's odd is ... where BMI is. So you've got the height and weight for some of the specialists as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, in the core measure they're allowed to record a zero if they self-declare that that's not relevant to their specialty, right? I suppose actually it could be one, so they did one blood pressure and it would show up. But for all these measures there's no threshold in terms of qualifying for the payment, just that you report.

M
For providers ... the year thing, for hospitals is it per year or is it per admission? That was one of the questions.

W
... admission ... patients, correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The question is should it be per admission? This is the last question in the—

M
If they were admitted twice during the reporting period it would still only count once.

M

They would only need to have one vital sign.

W
... more vital signs than that. You have to do vital signs to do CPOE. BMI was the new one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What we measure may be different from what they do. It would be crazy not to have vital signs from every admission, clearly. Do we need to put in our rule or not, I guess is the question. Or can we just leave it consistent with the old one?

M
I think consistent.

W
Yes.

W
I think your point's well taken. The unique patient thing only means it had to be documented on that patient. It wouldn't have to be for every encounter. It's a patient-centric criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It wouldn't have to be for every provider either. So if somebody's come to our group over the course of a year and I didn't take their blood pressure but somebody else in the group did, the patient would qualify and that would count for me and for the other provider. I don't recall the certification criteria. What's the look back period? Is the look back period equal to the reporting period?

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that means that a vital sign has to have been recorded in that 90 day reporting period, okay, one way or another, right.

W
... It's just a change. It's a change, that's all. It's not that it can't be done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any special things on the specialists? In other words, a dermatologist has to record these vital signs if they see a patient during that three-month period?

M
....

W
Unless they were still seen by somebody else who did it, yes.

M
It would have to be somebody in that practice, so it's ... in the same EHR unless it's captured through HIE.

M
What's the exemption for the ...?

W
....

M
So they're the dermatologist that ... the exemption. They don't need to—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Of not being relevant.

M
Yes. Is that the case? I thought that CMS had designed it so specialists who don't do—

M
We're not asking them to get rid of that. They're already set.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

M
One question, I think it's a legitimate question about the two-year-old to three-year-old.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. I don't know what age. I guess they could get out of it through the exemption, too, they can say it's not relevant for two-year-olds to three-year-olds as a workaround. Because we're raising it to 80%, so suddenly you need to make sure that all of your patients are relevant.

M
That wouldn't exempt the provider. That would just take those 2-year-olds to 3-year-olds out of the denominator.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It may not be designed to remove things from the denominator. It depends on how it's worded in CMS. I don't have the thing with me.

M
In other words, if you have infants in your practice you wouldn't want to exempt pediatricians from them, right?

M
Right, exactly.

M
But that person wouldn't qualify, so you'd have to take them out of the denominator if you wanted to do this right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we need to just check the age.

M
Right.

M
This is something that's actually come up from the regional extension centers as well because the guideline is three years and the measure, as it's stated now, is two and I think that's what has caused the confusion among the pediatricians. So that's something that we should just address, but it's a pretty—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was going to say it will be done in the rule making process. Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
Paul, when we're talking about these exemptions it reminds me that there was that whole issue with the ED patients; you can count them if you want, you don't have to count them. And it just feels that we need to weigh in, but it feels like that should be clarified with stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So this is a rule making process kind of thing. Okay, we can move on to recording smoking—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're at 50% unique patients over 13 have smoking status recorded as structured data, moving it now to 80%. The comments didn't have an overwhelming wanting it not to go too high or not to go too low. We seem to be okay there. There were a number of comments about the definition of what is smoking and whether that should be expanded a little bit. Then there are some certification questions.

One thing I just want to point out is by making smoking narrow we allowed ourselves to apply it to more specialists. In other words, as you broaden the definition then you have to wonder, to give a concrete example, it's one thing for the dentist to know if the patient smokes, but there are different things for the dentist to start asking, do you inhale second hand smoke, because it becomes less relevant, which is one of the suggestions here. As we broaden it we probably narrow it to just primary care providers, or potentially do.

W
George, I'm not sure I agree. I agree with your one example, but if the dentist is asking do you smoke, and I say no, but I chew, okay—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Chew would be important for dentists.

Christine Bechtel – National Partnership for Women & Families – VP
Right, exactly. I think the notion of changing smoking status to tobacco use, I think there's actually a lot of validity there. I have some question for Charlene about what the impact of it is. If it's simply do you use tobacco in any form, yes or no, then I don't think it's a big impact. If it's do you use it and what kind do you use, and then they have to document the type in the record then maybe there is more of an impact. But I think going, at least at a minimum from smoking status to tobacco use is actually, there's a lot of wisdom there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're talking about the public health issue is inhaling cigarette smoke, I think.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There is a concern as well about the use of chew.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's not a question of whether there is concern, it is what's the big issue that we have to deal with? It's really the inhalation of tobacco smoke. We're not solving the world's problems with tobacco.

M
We're excluding second hand smoke in this approach, so I think that what George is saying is it narrows the start. It's a way for us to start down this path.

W
I think with the changes that we did make to this point, I think the vendors will just keep the standards the same ... is kind of the consensus.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It appears again in the National Quality Strategy as basically inhalation ....

M
Is there no second hand smoke mentioned in the National Policy Strategy?

W
Second hand smoke? I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's mentioned. So again we're not solving all the problems, we're basically trying to move people in a line that has a high degree of impact, and clearly the—

M
There's no argument. It's just that you said this is aligned with the strategy and I just want to be sure if the strategy said second hand smoke that we acknowledged we're not following that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We had talked about smoking status as part of health risks and I don't remember what it said about second hand smoke.

M
We definitely want to have a way to capture that information, right? So are those in the standards now in terms of capturing the information on second hand smoke and other uses of tobacco? I don't think so. I don't think it's in the certification criteria. It's a good standard of practice, right, and if we don't have a place in the electronic health record to input that information when we're going through a smoking history then you can't really capture it. That's information that's lost that can be useful. So I don't think we need to put it here in terms of requiring it, but I think it's one of those things where you wouldn't want to limit people's ability to do good practice and comprehensive care by not having a place in the electronic health record where that could be captured.

M
That's a good point. I want to—

M
... second hand smoking in the system and we don't want to measure all specialists' ability to get meaningful use by using those fields necessarily.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We wanted, in the certification criteria, to be able to capture the—

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, but you don't want people to have to keep re-programming the smoking section of this stuff. If it's an important thing to capture, we should capture it now but not require its use, which I think is a perfectly reasonable thing to do. We don't have to measure every single thing that we want the EHRs to be capable of doing.

W
... paper that was sent out about the family health history. Is this topic relevant under the family health history discussion?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was just going to add that I think after we finish this discussion. I guess we're on the slippery slope argument. There are lots of things you would want in an EHR. I don't know how much that it's wise to do

within this one program. I think we're in agreement about shifting the threshold from 50% to 80%. It has the attractiveness of not requiring any new functionality or new certification criteria. Fair? Okay. Let's move on to—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, I saw a lot of head nodding at the suggestion that we call out certification for a more comprehensive way of capturing that tobacco use and second hand smoke. Can we get a consensus—?

W
... now.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that would be helpful.

W
I don't know that answer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. It's important to capture. I'm not sure it's important that we capture it right now. But we certainly need a placeholder for it so it doesn't get lost. So, one, we can ascertain what systems are currently doing and two, put it on our stage three consideration.

Another one that came in was from the NIH talking about structured family history. We all know that family history is an important indicator about the health risk for an individual, and we did not have anything like that in our stage one. We could consider something for stage two. We could consider something for stage three. How do people want to push that?

Christine Bechtel – National Partnership for Women & Families – VP
I thought the letter was very helpful. There are standards that are in place, there's a Web tool that's publicly available. It's interesting because it's also patient reported data, which is something we have been trying to get to. I think it's something that we certainly want the EHR to be able to accept sooner rather than later. The notion from a patient perspective that I only have to fill out my family history once because I know that my providers and all of my different providers, that EHR is capable of accepting it, convenience is one of the most attractive benefits to the patient. I'd love for us to think about how to include this in stage two as a menu item at a minimum, if not core, simply because if the standards do exist and the Web portal tool is available it makes it attractive. I'm having trouble finding the downside.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The downside I think mostly is development. So the fact that there was a Web portal doesn't really affect the development for the EHR, as you know, since you led—

Christine Bechtel – National Partnership for Women & Families – VP
The letter said that AHIC actually went through the standards creation process, so I don't know how much the elements are part individually of certification. We looked at the tool and actually it's enabled so that you can import it if the data elements match ... at that point of getting from here into the system and actually have the system store them and capture them and do something with them at the point in question. I don't know that answer, but we looked at certainly the tools.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the workgroup that you led, the Quality Measurement Workgroup, on patient engagement measures clearly had these patient entered things as the center point.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, except that they were really primarily focused more on things like functional status and risk assessments. So it was a little bit different than a fact collecting of family health history.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the issues that has come up, and I don't remember where, maybe in the patient engagement section, the notion of how do we deal with that and how do you tag the source and how do you qualify it. That is yet to be worked out. I wonder if this is a stage three parking lot item and we, like others, try to find a way to signal the industry about the need for incorporating patient entered data and how to do that.

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure I'm following the first part of what you said about the source and tracking.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The providers need a way to understand the source of each data item, and as they start incorporating things that are patient reported they need to understand the context, etc. That's not something you know how to do, the functionality exists today.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but I think there's a significant difference between, you all are physicians so you'll tell me I'm sure if I'm wrong, between I'm telling you I'm on this med and I'm telling you my mother had breast cancer. You're not getting that data from any other source except me, whether it's on paper or not. So with family health history I'm not sure we need to flag it as coming from the patient in the EHR, because it has to come from the patient regardless. So what I would like to see, we have to leave flexibility for the fact that some patients are not going to want to go on an online tool and do this, so requiring it as a core item with a high percentage isn't going to work. But at least getting the system to be able to accept it so that providers can offer the option to their patients of going online before they come to a visit and filling out their family health history makes a lot of sense, since I don't think you have to tag it as sourced by the patient.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You always want to tag the source because, let's say it could be a source, another provider's EHR, for example, but it's always wise to have the source for any piece of data.

Christine Bechtel – National Partnership for Women & Families – VP
The source is never going to be anything other than the patient in this particular example, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So somebody can say my mom had lung cancer and the provider, in asking about it, will try to figure out is this a primary lung cancer or was it metastasis. So there may be some qualification that goes on in that answer and you just need to let the receiver know where it's coming from so they can decide whether to pursue further questioning, let's say.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't think it matters. I think we're going to end up tagging everything, so you can tag this too. But I was going to make another point, which is, I think this is going to become critically important because in a lot of the work in ACOs and stuff, as people are doing predictive modeling of what's going to happen to people, family history becomes an important element of the predictive modeling. I think that people who are going to have their patient in some sort of risk sharing mechanism are going to be expected to have family history information input on their patients because of the impact that it has on making predictions about people's future healthcare.

I think we should push this sooner, again, not as necessarily a requirement to capture, but to make sure that the systems are capable of doing it in a structured way. So that I don't capture it one way now and then two years later find out that I have to take the stuff that I wrote out in the big paragraph and now put it in some structured field. It's a very important clinical tool that's going to become increasingly important with genomic medicine and it's also important for research purposes. It's a very good way to solicit patient input, because as I said, the data almost always comes from the patient. And clinicians may make some annotations on it, and you can have fields for that as well, but I think having a standard way of doing it for all clinicians is very important. Mark?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Paul, could we approach this the same way we did for the drug-drug interaction. We used the word "enable" in stage two and then "employ" in stage three. I think I agree with Neil and Christine that we should push this as something that's going to happen and that we don't necessarily have to have it happen fully in stage two, but we're signaling where we're headed. I really don't know this tool very well. Is this tool ready for primetime inside of EHRs? Do we know that? Because this note from NIH says that indeed it's pretty close. I don't know—

Christine Bechtel – National Partnership for Women & Families – VP
We looked at it for a day, so we didn't have a lot of time. But we do know that you can export it in XML and there's a standard. What I don't know is, again, and I think the point that was made, I'm sure each system captures family health history, if they capture it in a different way, and that's what we can't live with. So what's so important right now is if this is what the standard is for capturing it, then that's endorsed and we start to build that in in stage two so that we can move there to stage three. Because I think that would be incredibly powerful.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'd be in favor of making this a menu option for stage two.

Christine Bechtel – National Partnership for Women & Families – VP
And you'll get push back because we don't know the standards. So again don't put the cart before the horse. Get it nailed.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Putting it out there is going to stimulate the industry to implement this thing. It's like having a menu option so that folks who want to experiment with it can, which is good.

Christine Bechtel – National Partnership for Women & Families – VP
Just to be clear, we are certified to the exact standard that we have to meet. And again that would affect time table.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Deven?

Deven McGraw – Center for Democracy & Technology – Director
I would much prefer for us to get the standards in the systems and then have some more conversation about it for stage three, rather than do menu for stage two, if only because this is the first we've discussed this, as opposed to everything else that's on this list that we've gone over and over. We didn't get public comment on it at all, and it's not as though it doesn't have some appeal to it, but I know that even within the privacy advocacy community people get nervous about overtly including other people's data in a health record that they don't have any control over. So suddenly if my record says that my mother has a history of mental illness, suddenly there are privacy implications for my mother in my health record, and I haven't even thought all that through and what that means. I think we should put the balls in motion but give some more thought to it before having it be menu in stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, and I can't remember where I read this, but that exact scenario came up in public record in terms of somebody's mother had it and then it showed up in her insurance application. Karen?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
One thing I wanted to point out was also that if it does become a menu item for stage two, that means that even providers who don't plan to implement it must purchase the technology.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Deven, your recommendation then was what?

Deven McGraw – Center for Democracy & Technology – Director
Here's the thing, I do get asked by my physician about family health history. It's relevant. It's happening. It's information that's being collected. To the extent that we signal that we needed to be done in a standardized way, that's a good thing. Second, I don't know that we need to—when we make things menu items we're sending a signal to the marketplace to do this versus creating the capability for people to do it. If we're going to send a signal, I'd much rather do so having fully vetted all of the pros and the cons, versus having the capability out there, people will use it in accordance with their practice, and we take some time to collect public comment on it for a requirement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Marty?

Marty Fattig – Nemaha County Hospital – CEO
Christine was ahead of me.

Christine Bechtel – National Partnership for Women & Families – VP
I agree, I think, almost all the way with Deven, but not quite, and maybe would propose an alternative. I'm not wanting to give up on the idea of having this as a menu item in stage two, in no small part because I'm not sure I understand how you get into the certification pipeline and into the product development pipeline without tying it to a meaningful use criteria, which applies to a discussion we had previously as well. So my recommendation, I think there's a lot of support for the idea, at least in theory, and I think over the next several weeks or months or whatever we ought to go and really understand with Charlene what's the state of play here. It is absolutely early in this process. This is definitely the first public comment, but by no means the last public comment period. I just want to say as a general point, I don't think we ought to take up to the table the idea of adding any new item just because we didn't put it out in this RFC, since we're so early in the process. I think there were some things that the public saw that were missing that we ought to think about. Anyway, I just would say maybe we should not make a decision on stage two, stage three today, but rather do some homework and figure out what's realistic.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil, or Marty, I think was ahead. Sorry.

Marty Fattig – Nemaha County Hospital – CEO
The only thing that I would like to add to that is I think we ought to take a look at whether this is eligible providers, eligible hospitals, or both. I definitely believe that eligible providers should be included. I'm not sure about hospitals, but I haven't had a chance to think it through either.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I was going to say that I think that in some cases we're doing the world a favor by calling these things out earlier, because if you don't call them out earlier they're all re-dos. I don't think we're doing anybody a favor by basically leaving it out because people are doing this now. I know we have family history data in a weirdly structured way on 100,000 patients, and I'd rather start now capturing that in a better way on new patients because every single person we captured on now the old way is going to have to get redone at some point. It's the same with the race and ethnicity stuff, it's like we're not doing anybody a favor by waiting. If there are standards that are ready to be implemented we should get them in the systems now and call that out so that people aren't re-doing all this work in the future.

M
And this has implications for HIE, continuity of care document, this type of structured data should be in the CCD. So I think it's important to get it out.

M

We don't know what we're doing so just—

M
And ... to get patients to enter their data and having that transferred into the EHR, then there's the doctor's interview of the patient to try to ascertain what's really the family history in a clinically relevant way. What's the standard for that? I'm not sure there's a standard. That's a different level of detail usually than would go in the NIH version. I don't—

M
... the Standards Committee to say we need to establish a standard for capturing family history.

M
There are many components to the patient history besides the family history that are very important, like the physical exam, yet we're not asking them to come up with a standard for the physical exam. If it's as complicated as a physical exam, then we might get in trouble. So I'm a little worried about running in without knowing what it is we're asking for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We called it a stage three, but I wonder if it's really almost a signal list and we have to figure out how we do this .... I did notice somewhere in the summary that vendors started down a path based on "signals" from the health community, so vendors are using this communication in some ways in figuring out what their development plan is. Maybe we can have a more formal way of putting things on a signal list that are much better vetted in the sense of the value to the clinicians and the need for it in EHRs without having yet fully vetted the requirements, including the standards available, etc. So there's a signal list that we have to work on how to create a helpful, a useful signal list.

W
And to add to where their standards exist and vendors have confidence in investing so that we can be on the same page. That need for standards, and I'm not saying that we can even get there with those cases, maybe we can't, but that need for standards is one of those things that really helps the process.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In fact, it's possible that there's a list that we can give to standards write now and see if they can't get back to us in time by our June final recommendations. I think all the systems have an ability to capture the family history and all of them capture it differently. That's just the current state. Everybody would rather have a better state. So one question for the Standards Committee, is there a standard for that? Because then I think we'd be much more willing to move. Have we finished this one?

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I just want to register my support for your last comment. Unfortunately, I have to attend a board meeting at ACT so I'm going to have to sign off. I'm sorry, folks. I'll catch up with you later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one is CDS, and I think we had agreement on the value of not being prescriptive, the value of allowing for innovation, and now we also have the benefit of now the National Quality Strategy and some indication, for example, picking on cardiovascular disease as one of the early high priority conditions. So these all serve as guidance, both to us and to the community.

One of the very helpful things I think that was in the public comment is a better way of describing the eight they reduced to six rules that was found in the footnote, and I'll go ahead and read those. "EHR provides a method of displaying to the provider the source/citation of the CDS. EHR allows rules to be configured to enable system support based on the patient's context; clinical visit, currently admitted. EHR rules respond to information in the chart about the patient's problems, allergies, meds, demographics, and vitals, allows rules to be configured to present the system support at the specific point during the clinical workflow, can be configured to present decision support to users of certain roles, and can be integrated

with other applicable EHR functionality." So that's a revision to our phrases that we listed in the proposal for stage two. That seemed to be a little bit more specific. Comments on the comments?

One of the questions they asked is how would you tell that this was being done? I think the way that this has been rewritten is more amenable to creating certification criteria against them that ...value the way it was rewritten. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The goal of the attributes is that the EHR product should allow providers to achieve reasonable decision support. So do the attributes go in the objective or are they footnotes to the objective? Do you want to measure these things, even the new list, which is better, but do you want to measure those? Or, do you just want to end up in the certification and then what we measure is just ask the patient that they're doing some kind of decision support.

M
The goal was to target the certification criteria, and that's why the attributes—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Because a lot of the questions are, because he said that explicitly if the questions are, are you sure you really mean that? We're afraid that it will be interpreted as we're supposed to actually report on those certification criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, we can certainly clarify that. These are targets for certification criteria that leaves open the flexibility of how they implement things that influence the decisions that are made. Any other comments?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
How are we going to handle high priority health conditions?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Refer to the National Quality Strategy.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Can we put in something that says—

W
... establish them.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Pardon me?

W
Which really didn't establish them so much.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Let's say they come up with four, and we have a rule that says that you can attest that the four are not relevant to you because of your practice as a chiropractor is just not relevant to those four there. I'll pick one that is. ... do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, I think what we can be more precise about is you get to pick the high priority condition, because we also talked about how things are local, and the National Quality Strategy also said that. You just need to find out what's relevant to you, apply something that meets these criteria to be able to influence the way—these are all things people want to do anyway. We're just making sure that the EHRs have that ability to specify things that are patient specific in the workflow essentially.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so we're agreeing with the previous thoughts. Good. Okay, next is drug formulary. We're getting there. The EP eligible and eligible hospitals, the objective formally was that the drug formulary checks would be enabled with at least one internal-external drug formulary for the reporting period, and we want to move that from menu to core. This general agreement with it, the issue is what do you do in situations where a provider really doesn't have a formulary or they deal with many payers who have many different formularies and do they have to do all of them, or one of them? Well, we do say at least one. But what's the cost if you have—I guess the concern is that if you have ten payers do I really have to pay a lot of money just to connect one of them when it's not a significant part of my practice. So I'm paying a lot of money to do that, in effect, or energy into that, when it's not really going to pay off for my patients in a real way.

I think we said at least one, and it could be even one that you made up, because we call it internal. So we say, okay, it's the PPIs and the statins that we want to concentrate on because they're dispensed a lot and we're going to try to move from this to this general list, and that would qualify.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's true.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... by that, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Essentially our previous, it was just moving it to core.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Can somebody remind me why we put this in, in the first place?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It was one of our attempts at efficiency.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, but—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... the formularies are changing all the time. I'm not sure that you're more efficient by doing this electronically for one or two of your payers. The data's almost always bad. That's been our experience. We had it completely implemented using an external vendor and we shut off the entire system. It just didn't add anything. I don't know I just—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Were you going through a third party or directly to the payer?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Third party.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the problem, because you lose the patient specific formulary. So if you go directly to the payer you can get the exact patient specific formulary depending on what that patient's benefit plan is. When you go through a third party you often lose that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
With 45 different payers—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You need to be using a network. If you're using an intermediary network that can connect you to the right payer and you get that patient specific data, then there's huge value to that. But it's not always available. Deven?

Deven McGraw – Center for Democracy & Technology – Director
I suspect one of the reasons why we put in here an addition to efficiency is that it's always helpful for the patient to be prescribed a drug that's actually covered by their insurance company. So the formulary check encourages that process to take place in the office before the prescription is written. But if the data isn't good, then it doesn't necessarily even accomplish the objective we put it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I would agree with what Neil said in terms of it's very hard to get accurate information by patient. And so the approach that we've taken is really you focus in some high use drugs and move them to generic, which is still part of "formulary." It does clearly deal with cost, it is one of the biggest cost drivers, and it is "internal," but it's all allowed within our objectives.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm sorry, but I don't remember this. Did we consider the generic substitution to do that as opposed to trying to deal with the formulary issue?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We did and it was taken out.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We put it in and somebody else took it out?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It didn't make it in the NPRM.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We should put it in again. I think that's much more valuable than having all of these different formulary pieces. If there's anything that people will benefit from more universally it's generic substitution. I think we should try again.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fair. Folks, do you want to weigh in on this?

M
What does "internal" mean versus "generic substitution?" Are those synonymous, or how are they different?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Internal means that you have decided versus using a third party. That was the difference.

M
But did the fact that someone decides to use a generic internally, is that not achieving what Neil is describing? I'm just trying to make sure that it's really not there and if we need to put it back in or not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The current wording could encompass what Neil is proposing, but we did have a specific objective for generic and maybe that's actually, I think I would agree with Neil that that is probably a more useful thing to do and you have a better handle. Everybody knows what's generic, and people do not know what is paid for by an individual's plan. Neil, are you actually talking about therapeutic interchange, where you exchange a generic compound for a brand name compound, a different molecular compound that's therapeutic interchange versus generic equivalent, where you're talking about the same compound brand versus generic variety of the same compound? They're two different things.

Neil Calman – Institute for Family Health – President & Cofounder
The first one is not what people refer to as generic substitution where you actually save money, because in most practices now generic substitution with the same molecular compound is very high—

M
Yes, it's—

Neil Calman – Institute for Family Health – President & Cofounder
But if you're prescribing expensive brand name drugs and a therapeutic class and there's a generic drug in the same class that's a lot cheaper, that's a different concept. That's where you're going to get more value and saving money.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No question.

Neil Calman – Institute for Family Health – President & Cofounder
Especially for Medicaid programs, that's huge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do we want the capability in the systems to build decision support that would enable the second for sure, which I think we have in the decision support part. That's not really formulary so much. You're not taking something off formulary, but you could put in a decision support that basically is triggered by the prescription of a high cost drug that recommends the prescription of a lower cost drug. So that's one way to deal with those kinds of issues. I think there are a limited number of those situations that people can build in in decision support, because those are really clinical decisions that a practice would want to make. I don't think you'd want to build them in in a standardized fashion. The generic substitution piece with the same chemical formula I think is something that should be built in, even though I think it's around 80% now. But there's still a 20% margin there where people are still not doing that and that 20% is probably worth some astronomical amount of money at a national level. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think in the long run having a system that's capable of going to a formulary is a good thing. We've already gotten it through certification in effect because it was part of the menu item, and the question was, first of all, when we say should we leave it menu, I don't know what that means. Because if we end up with one menu item then you can pick zero and it's not there and then if you have to pick one then it's required. So we may not have a menu concept anymore. I'm just pointing that out. Is it possible to move this to core but not put an undue burden if we're not really ready to do formularies? We did say that we did want to remove things over time, but this feature in an EHR is a good thing to have going forward. I think that was along the line of the compromise that I was going to propose.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. In other words, for the reasons you suggested we already have it in the systems and we'd like to have the ability to use formularies. Because they're not totally accurate per patient now, we can explain in our preamble that this formulary concept includes moving to generic substitution according to either the chemical or the therapeutic, because most of ours, including our rules, are really shifting a drug from a trade to a generic. But that is still consistent with the concept of formulary, so I think we can have a ... in the sense of include what you talked about, Neil, which is where I think a lot of the money is, and yet keep

the same functionality. Since, for whatever reason, our initial objective did not make it through the proposed rulemaking, I think it is safer to go with the existing terminology but explain that generic substitution is part of formulary decision making. How's that? I'm getting a lot of head nods. Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
I agree with Deven, first of all. By the way, this is an important criteria for patients. But I'll also say that this is a really low threshold, so I was just reading it again, you only have to be connected to one payer, the payer capability. So it does seem like moving it to core because it's already in the system just make sense. My last comment is I love where you just went. We have a lot of discussions here about the intent of these criteria and I think that gets lost in the execution on the average Joe. So to think about incorporating some sort of column where we comment on why are we doing this, why do we think this is important in life is so important, because people don't have a sense, I don't think, necessarily of where we're going. So I really like your last comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. Josh is writing it down feverishly. Okay, are we ready to move on then? Is it my turn?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, the advanced directive, so lots of questions. One of the high points in terms of the discussion from the comments is who's responsible, and that applies both to the specialists versus primary care and hospitals versus primary care. I guess I'd have to agree that it seems like it is the person with the closest ongoing relationship, which is generally going to be the primary care provider, is the person likely to have this discussion and to record it. How do other people feel about that? Then we can decide on the implications.

Christine Bechtel – National Partnership for Women & Families – VP
I think it depends on the question we're asking. If what we're trying to achieve at a very basic level is the asking of the question do you have an advanced directive, I'm not sure that that needs to be only the primary care provider or even is primarily the primary care provider. I'm okay with multiple providers asking me do you have one. What we're also proposing in this stage is, okay, if you have one what is it, so that we can record what it is. What we are not, I don't think, trying to do is to force the discussion of what it is. If that happens, okay, fine, but this is simply do you have one. And if yes, what is it so that I can document it so that it can be accessed when it's needed. I think that's different than the conversation between primary care, which I would agree is primarily primary care, where this is important, it's why you should set this up.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually that's another one of these preamble things to explain. So what Christine is saying is this is only indicating that if you want to qualify within the reporting period and you meet this person you should know whether this person has an advanced directive, and if so does it exist in the EHR. That's all that's required by this objective. You're saying anybody should make sure if you're seeing someone 65 or older that those two statements are acknowledged, correct? Okay, Christine's nodding. Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The way we look at that then is you would document your measures, did the discussion occur, and a second measure would be what's the—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, no, no, actually, it's just whether they have one. And that's a good point, it only says does this person have an AD and if so is the AD in the EHR. They're not responsible for doing the discussion and they're not—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

All right. So it would be two measures. Did they ask the question, do you have one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And if the answer's yes, percent stored?

M
Correct. ... legal problem with electronic representation of that advanced directive in some states where it actually needs to be written and notarized and everything is not going to put providers in an untenable situation if there's an emergency and they pull up this electronic copy and it's not legally admissible in that state.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's not making that statement, though.

M
It is only saying for half of your patients 65 or older do they have an advanced directive. That part's fine, but it's having it on the system in electronic form.

Christine Bechtel – National Partnership for Women & Families – VP
It is saying that in whatever form, so yes, it exists, and it exists according to your state law, and that is great. And you have your notarized piece of paper and whatever the case may be and what does that piece of paper say, and that goes in the EHR. We're not trying to—

M
... have to have a scanned copy in the EHR to make that legal, because in an emergency if I'm the emergency room doc and I open up that EHR and it says that in there, if I don't actually have the scanned, notarized copy can I act on that? Is it actionable?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was raised by the comments too, and I would totally agree. I would like to see the handwritten document, and so I think most people would scan that in because there are official forms, etc., just like the ... but I think that's all consistent, again, that we should explain in the preamble. I think we should do a much better job in the preamble. We are only asking that it be known does it exist. If it exists, is it in there? And it doesn't even have to be in there, just is it in there? We all agree, I think, that people that are going to make decisions based on it are probably going to want to see the hand signed document.

Christine Bechtel – National Partnership for Women & Families – VP
Actually, I'm not completely sure I agree with your last nuance that you just stated. My interpretation was if it does exist then it is in there for 50% or some percent of patients, right? So it may actually be that this needs to be two different things. One is a yes/no, and one is of the yes, what percentage exists?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

W
....

Christine Bechtel – National Partnership for Women & Families – VP
Correct.

M
... has to be explained in the preamble that if it does exist in there that there might be a preferred way of documenting it on the system in whatever state according to state laws.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I almost think we ought to say it should be scanned. I'm not sure anyone would act on anything else other than a scanned document. So we're seeing a lot of—

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, okay, so we're asking that it be known for 65 and older whether they have one, and if they do that a scanned document be in the record.

Christine Bechtel – National Partnership for Women & Families – VP
That makes sense to me. The only question I have is part of what we're trying to do is lay the groundwork for information exchange later so that when I show up at the hospital the one that's on file in my primary care can be accessed by the hospital. If they're scanned copies, is that still going to be doable? Yes, okay people are saying yes. So if that's the case then, great.

W
... but that's not where we're at with this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, now other comments that are very legitimate is once you have that it gets a little difficult to say whether it has been updated. So, for example, with or without, so let's say somebody faxed you a copy and you scanned it in your record, how will we ensure that that's your up to date version?

Christine Bechtel – National Partnership for Women & Families – VP
How do we do that on paper?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How do we do that on paper?

M
That's a huge problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a huge problem. We've scanned in the advanced directives for years just to have it in our record, because hospitals have a requirement to ask this question on admission. So we have them here, but again it's always is this the latest copy. It seems to me that there's no way to guarantee it, but it would be helpful, what we do in, whether it's allergies or meds, at each encounter we check whether it's been reviewed. So I don't know whether the functionality exists, and it probably doesn't uniformly, to say is this advanced directive still your wishes and at every point of contact we should be able to say mark as reviewed today. So that's something we could consider putting into the certification specifications to help this problem. We're not going to solve the problem, but there are other folks, like family members, that can help us corroborate that. But clearly knowing when it's been last checked will help us. How does that sound? There's a lot of head nodding.

M
I'm over 65 and I have five specialists and they're all disconnected, so they're all going to independently be asking me are you up to date on your advanced directive when I see them at least once a year.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't see why you should do that.

M
It's going to be difficult to—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's why it's important. Yes.

M
This is not a low bar.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's also not low importance. We were just visiting someone at home and she was getting on in years, and what she does is she has her paperwork right by the door so that if she gets picked up by paramedics she just grabs that. We don't need people to have to take that kind of responsibility. So to the extent we can help that, we need to, I think.

M
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But it's not a trivial issue from, at the very top from an outcomes point of view patients currently do not have their wishes carried out. When you do everything this is one of our tools, I think. ... lots of ... for public. There are other questions—

Judy Murphy – Aurora Health Care – Vice President of Applications
Paul, just one other thing. To that point that we were talking about earlier to think about the intention, to call out not just that you should know whether it's there or not but obviously the purpose of this is to have the conversation. So in this column where we're going to talk about the intent, I do believe our intent is to encourage the conversation, even though we're only checking for does it exist.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. So in the preamble we can talk about why are we even focused on this. It's really something the country doesn't do well now that's important to the patients and their caregivers.

Okay, I think that covers the questions. Well, okay we answered this question of whose responsibility is it to make sure that it's documented in the reporting period, and we concluded everyone. Next is structured labs. Structured labs, we had 40% of lab results coming in structured form and then we proposed to move it to core in stage two. The question surrounded well, what should the threshold be, was one, but also what about people who don't have a lot of labs. Should there be a threshold under which they don't have to meet this objective. When we moved it to core we really didn't move it to core because we said, well, we can't really move this to core, so we said where available. In other words, it's a way of getting out of the core thing. So now they're saying, well, what do you mean by where available? Is this core or not? Then for a group that has many, many lab interfaces the cost of actually interfacing your system to all the different labs you might to get to even your 40% might be onerous. So those were I think the major issues that were raised. Comments from people?

M
In the event that, for example, a statewide HIE has a lab reporting service, could each subscriber to that service claim that that service fulfills this requirement?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think it would just work. They could report their data to CMS and they would say definitely yes. It would just work for them and they wouldn't have to worry about it.

M
Right.

Christine Bechtel – National Partnership for Women & Families – VP
Just a couple implementation-wise, and I just want to make a comment. I think we're going to try and solve this one, but when a state does a reporting service then there's a challenge on how we're going to

certify that in terms of who gets certified to actually meet that requirement. That's just spinning my head right now.

M
In public health discussions, there have been discussions that individual hospitals or other providers can use a service like that, and that service can get certified. So I'm using that same model to say that this statewide service could get certified and then each subscriber could claim that as part of their certified system.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I would support that. The issue that we raised was, as you start to look at the concept of structured, we don't know what structured is. Structured is a very ambiguous term. We would actually do better, we know what orders are out there and having some threshold knowing how many orders have results back or something, and again, knowing it's not all of them. Because the intent—and I think we're missing this when we're looking at some of the lab stuff. The intent is to close the loop, and so the real intent is that we can place a lab order and send it to whoever's going to do the order, and we get the result back, and when we don't we know about it. And when we've got this broken up across three different objectives sometimes we seem to lose what we're trying to do here.

M
The intent is two-fold. There was an intent of being able to follow trends and stuff, and you need to do structured data to do that, so it's closing the loop to make sure you get all your results and then there's noticing that the hemoglobin's been falling or the creatinine's been rising slowly over time.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There's a third intent, which is that some of these lab values represent control and trigger clinical decision support. There's a whole bunch of things that come off of this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm trying to remember where we got this suggestion, but LOINC came in with an IE group, at any rate somebody recommended that we include LOINC in the standards, and you probably, well, it's not our decision really, we pass it off to the HIT Standards Committee. But it goes to the point we've got to be able to, not only for our own reasons but when we accept HIE transactions it's got to be labeled the same, so that's something we want to move on. I didn't know that they didn't already do LOINC.

W
... already?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was going to say I didn't know they didn't already, but we had a comment come from somebody.

W
.... LOINC is available from the lab, you accept LOINC and store like in the EHR. It's not mandatory.

Christine Bechtel – National Partnership for Women & Families – VP
There also is a note in the Information Exchange Workgroup letter that is actually a repeat of something that they put before the Policy Committee in stage one. Which is about because so many of the providers rely on hospital labs and we have a lever for hospitals to require them to report lab data as part of their meaningful use criteria using the LOINC codes, the vocabulary and the message standards. I'll never get this right, people correct me all the time.

M
If the hospital lab does not have that capability internally, there are services, which they can use which can be separately certified that will take their output and convert it into the LOINC format and then pass it along.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Josh, we just want to make sure we reemphasize that with the Standards Committee and want to make sure we use the lever with hospitals at least.

Josh Seidman – ONC
Where available. I think that's the thing that we have to settle right now is what do we mean by where available, which answers most of those other questions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you mean where it's available in structured form, is that where available?

Josh Seidman – ONC
We're giving an out for providers who don't have structured results available, so how do we define that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The first words out of my mouth were going to create a loophole, which I was going to say where available in LOINC, and then that would incent people not to ... LOINC. Eventually, we have to move the lab market by placing more and more incentives on providers to have this stuff.

Christine Bechtel – National Partnership for Women & Families – VP
I like the idea very much of having half those reports have lab results in LOINC. Do we need, I think we do, a separate meaningful use criteria? I don't think it's just a hand off to the Standards Committee, is it?

W
No, the standard is done.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

W
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
So we actually need the meaningful use objective of reporting the lab results.

W
That is what the—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

W
... workgroup is asking for.

M
... agenda and the public health reporting that is in LOINC format. That's where these conversion services will help a lab that can't generate it directly, they can convert it.

W
Yes, because the only other lever we have on labs is through CLIA guidance, and I think CMS has probably done what it can on that regard, but I think the point the IE Workgroup is trying to make is that we can reach hospital labs through these policy levers and we should do that.

M

... be a little careful. We can't reach most of the labs, but we can reach hospitals. So we just drive hospitals out of the business because the other ones don't have to do it and they do if we have a lever on 20% or 10% of the market and not the 80%.

M
Actually, didn't somebody say it was 75% of the market is labs?

W
It's hospitals.

M
It's predominantly hospitals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let's hear any more support for adding an objective for the hospital side, that hospitals who provide lab services report them out in structured format using LOINC.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
How about the point of care tests that are done in offices, do they need to be LOINC'd as they go into the EHR? Can you do that through CLIA?

W
....

M
There's another way to ....

M
You're right. They're CLIA waives, okay.

W
Can we answer the first question first?

M
If we're talking about focusing on the eligible hospitals, should we as well talk about the eligible provider who does the point of care test?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's do the first question first, which is the objective for hospitals who perform labs should be reporting their results in a structured format using LOINC.

Christine Bechtel – National Partnership for Women & Families – VP
I'm actually trying to also understand ways that might help the hospitals have business. Because if they are such a large share of the market and we have structured lab data as other separate criteria for EPs, there might be a very nice synergy there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And from an ACO and from business, there's a lot of reasons why they would want this to be true. Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I would follow that through. That would mean if I have a lab system in my hospital and they are the source of doing labs then now I have to certify that lab system that it outputs its results in a LOINC code so that it can import that into my EHR, whether that be a practice or the hospital EHR. So you've got another element in the certification process. Again, it strikes me that we're trying to certify EHRs and to make sure that EHRs receive their data inbound in LOINC. Is that where we're trying to go?

M
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
LOINC based—

M
The hospital laboratory systems are now being certified as LIMs, Laboratory Information Modules, which are part of the hospital's EHR. So that's how it's going with CDC and ONC on those calls. That's the current thinking on that. These systems are now modules that are part of a hospital's EHR, and they can be certified directly or in pieces, the laboratory system and then a conversion service can also be certified.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What I'm hearing you say is that there already exists certification criteria and people are using that.

M
That's what we're hearing from the CDC, ONC calls just one two weeks ago, where it was specifically stated that that was permissible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Karen or Josh, do you have guidance on whether this was within our scope? Jim Daniel from ONC is a public health expert.

M
I was on the CDC call as well, and yes, the laboratory information systems for public health reporting are being certified in a modular fashion, as James mentioned, and they can either be strictly certified as an EHR or they can be certified using services such as James mentioned that are in the middle within an HIE. And it is a model that I think you're implying could be replicated to report to physicians. In this case it wouldn't necessarily be that the eligible providers would have to certify the hospital system, because if you put it in meaningful use for the hospital it would be their responsibility to certify that technology.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So you're saying it can be certified, and is being. Is that the same thing as we can actually require that it be certified, I think that's a different question.

Christine Bechtel – National Partnership for Women & Families – VP
... you have what we've proposed already under public health doesn't seem to be at all dissimilar with the exception of the entity receiving the lab results. So in stage two we said ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs as long as the ... can accept it. So what I presume is in the certification rule for stage one anyway is that if you do this it needs to be by LOINC. So it almost feels to me as if we could say ensure that reportable lab results and conditions are submitted to eligible professionals basically, either directly or through performing labs. Does that make sense?

M
... what we're asking hospitals to do. If I'm using an EHR, which has a lab system, am I saying that it has to be stored in my database as LOINC codes? Am I saying that between these two internal modules they have to talk in LOINC? Am I saying that if you output, but why would we do that? Or if we're going to output it to an outside doctor does it have to be in LOINC? That one I understand, but the other ones I'm not so sure that they have to be stored in the database of LOINC, because it depends on how the database is structured. If you export data to a provider as if you were an independent lab, we want you to follow certain rules.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct, and the only question is whether that's a requirement that we can require for an EHR by a hospital, do you see what I'm saying? We're really looking at the hospital as a lab services provider and it's not the same thing as saying EHR ... provider. But if we can make some kind of argument like that it would certainly be useful. Again, it's in the best interest of the hospital wanting to provide these services anyway.

Christine Bechtel – National Partnership for Women & Families – VP
I think this has the feel of something that's pretty big and very important, so we should probably take some time and get it right. I think there's probably a group that needs to work on it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fair. But that's the intent, is to try to increase the use of structured data reporting in labs from the most common sources.

Christine Bechtel – National Partnership for Women & Families – VP
LOINC based reporting, or structured? Structured is the undefinable element. We don't know what the structure is. We know what you mean.

W
... standards, yes, ... standards that's a—

Christine Bechtel – National Partnership for Women & Families – VP
The data that you can actually ... report. We know what you mean.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now, my understanding is that LOINC doesn't cover absolutely everything, so I think there is a little bit of where LOINC codes exist. Marty?

Marty Fattig – Nemaha County Hospital – CEO
I'm just thinking here, thinking out loud. Is there a need to differentiate between clinical lab and anatomical lab reports? Anatomical probably is not structured in the usable format. I think we were ....

M
Yes.

M
... anatomical course, so those are structured as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We actually had this discussion, that's why we put clinical lab tests before. It's just where do we put the emphasis right now.

W
I've got a generic question. Paul, do we ... hospital labs don't export data in LOINC today, because we've been working on this for quite a while.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
....

W
They don't?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For example, in New York State as soon as you get out of New York City almost none of the hospitals do it. So we have a huge problem in New York, and that's why we're talking about central services to convert because each individual hospital lab cannot afford to do it themselves. So the state is trying to

step up to the plate and build a conversion service so that the hospitals can use it. Nobody else can afford it.

W
So that's going to be part of the thought process then?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

W
Okay.

M
In the case of New York, it's going to require state resources to build it because these individual hospitals cannot afford it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I would say, number one, we have to do more research. Number two, I wouldn't add a new objective, I would just say that EP is this, and EH, you have to import it and export it as LOINC, if we decide to go that way after we do our research. Now for EP we have to decide who doesn't have to do this, because I can't think of an algorithm to say you guys don't have to do structured lab reporting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They have to attest that their lab sources do not provide structured results. These are also ....

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
What if ... does? Do they do that one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They have to, yes. For every lab source that produces structured results they need to incorporate that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So if ..., because one lab may just be for cancer genomics results, so they may have 20 labs that they draw from, do they have to do interfaces to all 20 labs, each provider? I'm just trying to work out, I'm a provider sitting in the middle of nowhere, what do I need to do? Or do they just have to do it for at least one lab, would be another way to do it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well we wrote it as 40% of all test results ordered in a reporting period, so they would have—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right. In core they would have to go where the results are, and most of it's going to be clin labs, so they would go after the clin labs and try to do that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay. So it's attestation and then 40%, and we have to look at hospitals?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we're going to look at hospitals. Okay, generate patient lists, general agreement to move that from menu to core. Not really much disagreement, so I propose that we just keep it that way which is to move it to core. That's pretty basic functionality.

M

... we could ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Patient reminders, 20% of unique patients over 65, or less than 5 were sent a net reminder, and we're making that a core objective. The questions are the denominator and the numerator in definitions like what's an active patient. One thing, is it just the primary care provider has to do that or do the specialists also have to do that? That's one of the questions. The second is, what is an active patient? Third, there were also questions in the other direction. Should it be for more people and not just that limited group? Active patient I think we can define off line. Does it apply to all providers? The default is yes. Does anybody disagree with that?

M
Is there—oh, this was menu before.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

M
Are there specialists for whom this doesn't make sense? It includes a reminder to make an appointment.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, don't they have the ability?

M
... follow up care.

Christine Bechtel – National Partnership for Women & Families – VP
Right, so I'm thinking about radiological oncologists, and I'm probably not going to need a reminder for follow up care because he's delivering a report, or she's delivering a report back to my primary care—

M
So consults in general—

Christine Bechtel – National Partnership for Women & Families – VP
But can't you exempt yourself from this by saying this doesn't apply to us? No.

M
We'll check on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It may have been an exemption because it was menu. I forget now. Because once it's menu you don't have to worry so much about exemptions. Now, if we put it in we may need an exemption if it isn't there already. Okay.

Christine Bechtel – National Partnership for Women & Families – VP
The other issue, though, that I would raise here is the issue of age. So this was a big thing, was not limiting this to 65+.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The reason we limited it was because we wanted to have a threshold using all patients in your database, all active patients. So we thought at least one and five in this age group is eligible for something, and honestly, this obviously looks much more like preventive services and routine follow up, so there are specialties where that may not make sense.

Christine Bechtel – National Partnership for Women & Families – VP

Right. I'm sorry. I'm ... topic thinking of primary care, I guess, one of the things that because it is preventive and follow up care you should have lots of opportunities for patient reminders. So to limit it to only people over age 65 doesn't feel like it makes sense. It might make more sense to have a low threshold or frankly maintain a low threshold but have the denominator be much broader.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think this is along the lines of once you start implementing this functionality, using it, you're going to want to use it for all the other reasons, whether it's your own clinical care or care across an ACO, this is functionality that you really want to depend on. So what we're trying to do is make sure that this gets into your workflow. We tried to find, and this is actually I think it came from CMS, this whole notion of let's look at your whole base and just pick some number where it's reasonable to think that you're using the functionality. This is an attempt not to be prescriptive, but to start implementing this very useful functionality that people are going to want to use. They don't want to use it just for ....

Christine Bechtel – National Partnership for Women & Families – VP
No, I agree. I think my problem with it is that we were very prescriptive. We said only a very small portion of our patient population, or a very targeted portion of the patient population, is 65+.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's because it's very likely that they're going to need one of these reminders.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but for anybody 20+ they're going to need a reminder for preventive care or follow up care, and so I think that was something that a lot of folks were concerned about, and, by the way, the tie to the other criterion, patient and family engagement, which is mode of communication and .... There was a lot of support for that too. So I'm just feeling like if this is so easy then it should be pretty easy to expand the age range, particularly when it's tied to other criteria as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I'd leave the age range completely open. Kids need to get reminders for immunizations, things that are overdue, and health maintenance things, and I can't imagine that there's a group out there that couldn't meet a 20% threshold.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Remember, there's who needs it and then there's their preferences. So what we did in the first discussion was what's kind of a reasonable threshold. We picked this group because we were trying to offset the effect of preferences and we didn't want to have to measure or track preferences in the numerator or denominator, so that's how we ended up here in our discussion a year or two ago. You can say, well, we should get rid of the age group, leave it at 20%, and in effect bumping the percentage is a form of bumping the percentage in stage two, if we got rid of the age groups.

Christine Bechtel – National Partnership for Women & Families – VP
Bumping it down, though.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, bumping it up. If you leave it at 20% and get rid of age restrictions then in effect you're making it a little bit harder, but this is stage two, not stage one, so you can make that argument.

Neil Calman – Institute for Family Health – President & Cofounder
It also ... the menu to core.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and I'm not sure, I mean, one in five of your patients 65+ going to one in five of all of your patients. Somehow to me it seems easier. I don't know.

M
No, it's harder.

Christine Bechtel – National Partnership for Women & Families – VP
It's harder. All right, well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's harder because the over 65 has the greatest prevalence of needing it. So if you include people with a lower prevalence you end up with making the requirement a little bit harder. So what maybe we can do is, I think we should expand the age range because it's important to make it more relevant to everybody and feel that everybody's sort of included in this. So I think it's important to expand the age range. And whether we do that by lowering the threshold or keeping the threshold the same, that's something we should look at.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The balancing argument here is it was menu, and a lot of people chose not to do this, partly because of its complexity, and what we're trying to do is push it along, get it on to the escalator. If we change the rules and make it mandatory I think we might be pushing things where we don't need to. That's the only point.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
What if we lower the threshold 10% and make it across all ages and make it core. I don't think anybody would have a problem with doing this. We're trying to call out a use of the EHR that's not going to be called out any other way except to say we're expecting people to use the EHRs to do something proactive with the population of patients. Everything else we're doing is kind of like with people that are coming in, and this is one piece that we're doing where we're basically calling out the use of the EHR to engage a broader group of their patients.

Christine Bechtel – National Partnership for Women & Families – VP
By doing that we will be engaging a larger sub-set of patients probably proportionately a higher percentage of which will actually want to be engaged electronically. So if you bring the boomer population and the Gen X, the Gen Y'ers in, they're going to want to receive a reminder via e-mail or text or whatever the case may be, and so it begins to allow you to focus a little bit more on technology. I understand the workflow implications for clinicians, but when I think about the workflow that a patient has to do to manage their whole life and try to remember to go where, where, how, I think this is better for a broader group. I like the idea of 10% of all of your patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I just wanted to clarify, it says "were sent an appropriate reminder," so if my EHR automatically calls everybody who's supposed to come in tomorrow, is that sending an appropriate reminder? Or, are we talking about preventive care visits and immunizations, which I think was the sub-text of all the comments before this. I just want to know, if someone just hooks up an interactive voice response to call patients, is it meeting this criteria?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it is not. In other words, appointment reminders would not qualify.

M
Wait a minute. If you get rid of appointment reminders then I'm back to the specialists, well, preventive care should certain specialists—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Preventive or follow up. So if we did—

M
... will tell you what the ....

M
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If it's GI and you're going to be following up on anybody that you did a colonoscopy on that's got polyps that's got to be followed up in a year or two. If it's dermatology you have people who are high risk because of sun exposure and they need to have skin checks periodically. It depends upon managing a population of patients.

W
I do think that appointment reminders absolutely count as reminders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You do?

W
I think they do, because we want to say you need to come in, in six months for your skin check.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Then we should do that as a separate—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's make sure we understand what we mean by appointment reminders.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
When I describe appointment reminders means you have an appointment, I'm reminding you that you have that appointment, which we do for 100% of our patients. Are we at 100%—?

W
Versus you make an appointment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. It looks like a lot of head nods about we're not counting the fact that you call or that you have an appointment.

W
But you need to make an appointment.

Christine Bechtel – National Partnership for Women & Families – VP
Something that really helps with clarifying these situations is if you say, for example, and then put your examples down, make an appointment. In the rules, like ... stuff, I know the questions we get are do they mean this or do they mean that? If you give some examples and say but not this or something like that, that's helpful in terms of clarifying ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so the proposal so far on the table is expanding the entire, is it the entire active patients, I think we have to say that, and we're going to have to define active, that 10% of them will have received an appropriate reminder for preventive services or follow up.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Shall we say sent or received? I forget. In the RFC, what did we say there? Does the RFC say "sent" or "received"?

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, somebody—

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so—yes, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Just a comment about availability, this is available on most systems today, so that's not so much the issue. This will probably require us, you would think it would, have to go re-certify it to broaden this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
To do what? I'm sorry.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
To broaden. To demonstrate you can do more than 65. The certification process is pretty specific.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that's one argument for keeping it the same.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The certification actually said to show that you can send a reminder to somebody over 65, are you sure?

W
When you go get re-certified you don't have to go through, let's say there's 60 criteria, let's say there's 20 new or changes or tweaks, you don't have to go through the process 20 times. You go through it once for all 20, right? But when there's a change, they were pretty specific on how to re-certify. And the capability is there, that's less worrisome, but it just takes you through the process again.

W
But I'm assuming you're going to have to go through the process again anyway for the rest of—

W
It's the low threshold one.

M
Can you look up that .... whether it was—

M
You're getting healthcare ....

M
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The criteria is enable user to electronically generate a patient reminder list for preventive or follow up care according to the preferences. And it has at a minimum the data elements associated.

M
So ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, good. So we're fine.

W
...., not the certification criteria. I do believe there are some strange criteria. I think it's patients over 65 who have an allergy to penicillin, who the heck would ever admit to that, but they're just looking at capabilities.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. I think we have finished category 1A and we are only—oh, Karen.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
If this is moving from menu to core, that makes it more important to define patient preference and how we're going to capture and verify it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

Christine Bechtel – National Partnership for Women & Families – VP
... communication medium under patient and family engagement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That would be required in stage two?

Christine Bechtel – National Partnership for Women & Families – VP
I don't know that it's required, but it is—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, the other comments they made were well, do they have one medium for appointment reminders and one medium for etc.?

Christine Bechtel – National Partnership for Women & Families – VP
Right, that's a great question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, it's a little hard.

Christine Bechtel – National Partnership for Women & Families – VP
There are two issues here. One is per their preference, which is I don't want you to remind me or I do. That was the original context that we talked about is do you want a reminder or not. Then there's the question of do you then say for those who want a reminder you need to deliver it according to the preference that they specify, which immediately does contextualize it because it is preference for receiving a reminder as opposed to whatever else.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. We said according to patient preference in stage one?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One way out is to say a low or even lower percentage so that we just basically are counting the number of issued reminders of one sort or another, and that accounts for folks who didn't want them. It's the same thing? If you have it low enough then we wash those folks out without having to add additional burden of documentation.

Christine Bechtel – National Partnership for Women & Families – VP
But wouldn't you have to document anyway—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that you don't issue it?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so that you don't issue it. So in that case—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The certification criteria include the notion of capturing preference.

M
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's being checked now, but it looks like it's enough.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

W
..., it has to.

W
If we make it core—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But the menu didn't, so that does mean—

Christine Bechtel – National Partnership for Women & Families – VP
How can you opt to do something that can't be done, to put a fine point on it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, these people did it by manual processes, I guess.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But also, that doesn't require that it be done in a standardized fashion, because right now we're not talking about passing that information anywhere. If my EHR can capture how I want results done or differently from other reminders, I don't think we really need to have a standard for that, do we? It wouldn't have to be done exactly the same in every EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Maybe it's like Christine said, we do have it under patient engagement. We're going to have to ... this preference information anyway and that will be the way we use it to exclude. So we either include this patient preference at one threshold or lower it so that we don't have to worry about it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We already did lower it to 10%. Do you want to lower it even more?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, does that account for people who just don't want to be reminded?

Christine Bechtel – National Partnership for Women & Families – VP
But you still, I can't get past ...you still have to document they don't want to be reminded so that you don't keep reminding them. I'd rather do something that gets the right process in place.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We will deal with the patient preference when Christine presents the patient engagement and we'll leave the criteria as according to patient preference. Good. All right, we're ready to move to 1B, which really only has two, and it has to do with the new functionality under category 1. And I think Marty has the lead on that.

Marty Fattig – Nemaha County Hospital – CEO
Thanks, Paul. Yes, I have the electronic notes is the first one that I see, is that correct, 30% of visits have at least one electronic EP note, 30% of EH patients today have at least one electronic note by physicians. There was a lot of discussion on this in the comments and the big thing I noticed right away was that 80% of the commenters believe that scanned notes should not be acceptable. I would agree with that. Physician documentation is a function that is currently being added to our HR system, so I'm hoping that will work as well. That is the piece of software that we need in order to meet this. Determining what should be included in the notes, there were a lot of questions about that as well and also the idea that because we want to be able to compile data from these notes, that free text should be searchable. Those are just some of the things that were brought out in this particular note and the questions that were asked.

If we go back to our intent, we wanted to make accessible key documents, that was our intent, as you know, it did not make it through the NPRM process. We commented on that as well. So we strongly believe that this kind of information should be there. Maybe we can take it in order. One is the overwhelming majority felt that they didn't want scanned notes to be used. We explicitly allowed it in our proposal. Do we want to accept their recommendation that we will not accept that? Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The pushback we had gotten was not that scanned notes, but it was the scanned handwritten notes because of the readability issues. So they detailed it to the next level. It was more about, and we got some pushback even shouldn't handwritten notes be accessible? But we got the pushback on scanned handwritten because of legibility.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think an issue is going to be whether the document is searchable, if you have a searchable PDF and you can scan it and that would probably be okay. You scan it in and it's searchable and you can search on it that would okay, but if it's not a searchable document it loses a lot of value. Other comments? So a proposal on the floor is that we remove the eligibility of scanned notes to satisfy this requirement, and I'm getting a lot of head nods. Yes, on this side?

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

M
Back to Jim's comment, so a scanned PDF is not acceptable?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A PDF isn't scanned.

M
It could be scanned and it could be searchable.

M
But an uploaded PDF would—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A text document would count. A scanned image would not count of any form.

M
Okay.

M
And it has to be searchable. A searchable PDF would count. A non-searchable PDF would not count.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It seems like, and the feedback that we got is when you have half your notes in your system and half your notes not, it gets really hard out there. So it strikes me if we could just get, it scares me to take scanned documents off because you just want to get the readable documents in there. And there are certainly a lot of ways people get them in there. I know it's an issue in terms of counting it, is it balance, because if everything's scanned, that's not the direction we want to go. But when there's half and half they need to be able to count on going to their system and looking at the data, and if there's a piece we exclude because it's a subset of stuff that comes in the front door of the office or however it shows up in the workflow. To say we don't accept it, that strikes me as a problem.

M
Well, the expectation is that they have to be able to pay a note. It's just not part of the 30%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So maybe the intent says that, or we just don't count it.

M
... scan in handwritten notes, which you would, but that's not going to count here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Especially during your conversion, we just want to move them in that direction, that's why the low threshold. Other—

M
... is the operative word, searchable versus scanned here. I'm trying to—

M
I'm trying to—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... is the intent. I'm trying to think. There may be a better word, but searchable is the intent.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're out ruling scanned images—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
..., okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then we're deciding whether to include textual documents that are searchable. So let's go to that second one. Are we including textual documents that are searchable by your EHR?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, okay. So in the preamble we can state that, which would also mean transcription is also okay. That was another comment that was made. Other comments, as Marty said, what counts as a progress note without being prescriptive? Going back to our intent, it's really key information being accessible, so things that were offered were admission notes, procedure notes, ..., all those are key information and we would want them to count. Right? Everybody's nodding. So have we cleared up all of the questions?

People mentioned ... format, we're indifferent to that. They can decide culturally ... but we need to get information in there. Okay, we've got wide agreement. Okay. Next.

Marty Fattig – Nemaha County Hospital – CEO
The next one I have is—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Possible is the same thing, right?

Marty Fattig – Nemaha County Hospital – CEO
Yes.

M
There was a discussion about patient days versus admissions—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We said patient days because we need to know what's going on in the hospital, and I'm seeing head nods again. Okay.

Judy Murphy – Aurora Health Care – Vice President of Applications
This is Judy. The tough thing for hospitals to get is going to be the ongoing progress notes as compared to the admission history and physical and the discharge summary. But with, what are we talking about, 30% threshold we're probably okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We actually wanted 100% because it is very helpful to have what's going on in a hospital—

Judy Murphy – Aurora Health Care – Vice President of Applications
I know. It's an adoption issue, not a product issue, yes.

M
It makes a huge difference.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You can actually read the progress note. If you're an ambulatory practitioner and you need to see what happened in the hospital and you can't read it—

W
I'm with you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Next, Marty?

Marty Fattig – Nemaha County Hospital – CEO
The next one we talked about is medication orders automatically tracking electronic medication administration records, again, lots of comments on this. The big thing that I think we're looking at here is tying this to CPOE and then coming up with a closed loop medication administration record, which I believe is a process that will take some time to accomplish. It is definitely the end result we need to be looking at, but there are many stages to this, the beginning of which obviously is the CPOE, and then moving to the EMR, Med Verify, MEDREC, and so on down the line. Some of the key things that were brought up, just again more definitions, and again I think that will probably need to go back to some other group other than this that clearly defined some of that. There are also some comments on here about using data from IV pumps and various other devices to be included. This is a complex thing that could really go in a lot of different directions. It does add a lot of value. But again I think the definition has to be pretty clear or we're going to get lost in the minutiae of the whole thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think one of the reasons this was brought up was I think Charlene mentioned how, and Judy, how this is happening in hospitals already. Why? Because it's of high value. We set a fairly low threshold for that. We're really talking about getting it going into the EMR is how we ended up. We backed away from the whole closed looped into EMR because that is one of your first points, really helpful to the nurses and doctors, but any comments on wanting to go off of our original proposed criteria?

M
It seems more like an on and off thing rather than a threshold, because either they're doing it or not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which units in your hospital?

M
That's why we had the percent, so you might be doing it in the ICU but ... in your implementation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

W
... outpatient is still an area that ..., yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In fact, there was a question, I think we intended it to be inpatient and not discharge, is that correct?

W
..., I don't think.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It can't be discharge, because you're not administering it. But there's nothing wrong with clarifying it, right? So for inpatient setting we're expecting that 30% of the hospitals' orders are automatically tracked through the EMR. Are we comfortable with that? Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes, I'm sorry. I didn't think about this until I just heard you say it. I don't know if it's the orders of the patients, because again if we go in a hybrid where individual patients have some of theirs in and some of theirs not, it would be extremely illogical and unsafe. So it feels as if we're going to have 30%, and it has to be 30% of the patients as compared to 30% of the orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wait, but then, so 30% of the patients have had an EMR somewhere in their course?

Judy Murphy – Aurora Health Care – Vice President of Applications
I know. I hear you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We did 30% of orders.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes, I think you're right, because if you're staging it across your hospital it would be patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. If the patient was in the ICU but then got transferred to the ward and then they had none, so maybe it accounts for staging and maybe it's a lower threshold. Let's see, this is new, so we get a chance to define it. Maybe it's a lower threshold because of that, and as Jim said, it's not as if you're going to do part of your patients, part of the stay on purpose. So we just need to show that you are implementing, that's what we're trying to do.

Judy Murphy – Aurora Health Care – Vice President of Applications
So to align it with CPOE, the processes, CPOE order will populate your EMR, right, that's the intent, your 60% with CPOE, and counting it differently in this measure because you're across orders. So I think keeping some alignment there would make it easier at the end of the day to count. Not that you can't do it both ways.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So then what would be your counter proposal then? How would you align with the 60%? Because the 60%—

Judy Murphy – Aurora Health Care – Vice President of Applications
I know. I just raised the bar.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Judy Murphy – Aurora Health Care – Vice President of Applications
But it's—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But you can have 60% CPOE in that order without having the EMR.

Judy Murphy – Aurora Health Care – Vice President of Applications
You can, of course.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we probably want to lower the threshold to just make sure that we don't run into unintended consequences, is that right?

Judy Murphy – Aurora Health Care – Vice President of Applications

Right, it would strike me as kind of on this patient as opposed to the orders, because we're doing patient on—

W
One would think that the hospital's way of implementing would be logical and not think of this as we're being prescriptive here and they'll do the right thing, because I can't think of a better way to say it, other than what you're saying, which is 30% of the orders, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Or lower.

M
We did seek some consultation from a couple of people, including David Bates, who's been doing a lot of work on this. I'm going to ask Leah Marcotte from our staff just to summarize some of the ways we've thought about approaching the definition.

Leah Marcotte – ONC
There are a couple of issues, the issue of implementation, because if you include this in certification all of the hospitals will have to actually purchase this, it ends up being a little bit of, obviously an investment. And so the idea of lowering that threshold is so that you can roll it out by department for stage two and so that it can be incremental in the investment and the upfront costs aren't as prohibitive, especially for critical access hospitals.

The second issue is with the denominator, to have an accurate denominator this really should be medications dispensed, not order, because if you put in an order it can be 20 medications dispensed, so that ends up affecting your measure. So if you do medications dispensed, it ends up being a pharmacy ... so you need to get that data from the pharmacy. Because in certification there's no direct requirement that your pharmacy and your inpatient have to be linked directly or need to communicate electronically, that may have to be a denominator that you get separately from the pharmacy system. These are just some of the complicated issues related to this measure.

One of the suggestions that we got was exactly what James said, is that if you just have this as an on and off function, if you are requiring people to purchase it. It's a huge patient CPOE benefit, the chance is that they're going to use it and they're going to use it for all of their medication orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that means just say it's in use, that's what you mean by on/off?

Leah Marcotte – ONC
It would obviously make the measurement a lot less complicated.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, realize we could say that about a lot of our things.

Leah Marcotte – ONC
Right, but—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I do want to ....

Leah Marcotte – ONC
If you want to use an accurate denominator it would have to come from the pharmacy and not from the EHR.

M
How about if we say it's in use for stage two and then impose it in ... in stage three?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We could be a little bit more precise and at least say in use in one of your clinical units. I can imagine there are ways of finessing the word "in use" but—

W
That would at least get at, Paul, that you're either using it or you're not using it. Not that you're sometimes using it for some patient some of the time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the nomination on the floor is in use in a clinical department in your hospital. Okay. So just another check on ourselves, these are two new functionalities that require two new certifications and the development and the implementation, and the test for ourselves should be is it that important? I just saw him just putting ....

Christine Bechtel – National Partnership for Women & Families – VP
I wanted to add a comment, another measure again. Most of these capabilities are in systems today and are being implemented today, so this is not new development function. We have to go through certification, but these are not brand new things that we have to develop, and in many cases they're rolled out in facilities, both of the items.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's really helpful. But I'm just trying to test ourselves against our parsimony. When we add new things we want to test, and I think this group has definitely felt both of these are of high importance, high impact, and in fact it's so high that it's already in our systems, it just wasn't required yet.

Okay, we're not doing badly. I think we can move on to patient engagement, which Christine and I think Deven's going to help back you up, Christine?

Christine Bechtel – National Partnership for Women & Families – VP
It sounds good. Yay! We're going to start with copy, but I feel like there are a number of repeating issues in the comments between copy, view and download for EPs, clinical summary, and view and download visit summary for hospitals, that it's probably easier if I start with just overarching what are those themes, and then we'll dive into copy.

I think probably the main ones are number one defining the data elements, and that includes for copy. People want to know what that means, so that tells me there's still some confusion about what our intent was with respect to copy versus view and download. And some real strong support for making sure that at least in stage two the data elements come directly from the CCR or CCD so that it doesn't require a lot of rework. I think we may want to ask the Standards Committee to help us understand what would we use over the definition that we've proposed in comparison to CCR or CCD?

The other technical side is some real concerns around the ability to filter and organize the information in a particular way by visit date, etc. That is something that's a very new function that people had some, particularly the vendor community had some real concerns about. The second probably largest issue Is our continuing discussion around the spectrum of how we measure these things. There are basically three options here. One is wait for patients to ask for the information and then when they do comply with that request about half of the time, that's what we're doing with hospital ... instructions today in stage one. The second option being actually proactively offer it to 80% of patients, but don't measure their usage, just make sure that they know that that's available. Then the third being establish a low threshold that gets patients actually using it. So there was discussion of that throughout the comments.

Then I would say a number of issues around adolescent privacy issues and caregiver access. So making sure that the right people have the right access and in the appropriate situations, which is more access for caregivers, particularly for elderly patients but probably less access for adolescents over age 13 when they're able to consent to healthcare services on their own. Then actually the last overarching piece in

this section is the issues around being more prescriptive or less prescriptive around the technical medium, do you deliver information via a portal, via a PHR, do you just make it available generally in some sort of standardized way? So those are the overarching issues.

On copy, there were some requests here to again define the data elements and to also think about combining it with view and download. I wanted to ask Deven what we think about that. From a personal perspective it's certainly appealing and I think there's been so much confusion around the distinction that I think that would certainly eliminate the confusion. Patients already have a right to their information electronically when it is held electronically under ARRA, so do we need a copy at this point at all, or do we just need to make sure that we preserve view and download kinds of capabilities?

Deven McGraw – Center for Democracy & Technology – Director
I actually do think you raise all the right points, and that we've already got a legal requirement to provide a copy when people ask for it. It's actually when that providers understand because it's information that's in what's called a designated record set, and if you tell me that you know what that is, then you win a prize. But there's at least a basic understanding of what HIPAA applies to, what patients have the right to get, and NOCR has already put out a proposal that basically says if you've got it in an electronic format and it's information in a designated record set, when the patient asks for it you need to get it to them. I think the only thing that they haven't done that I hope they will do in the final rule is set some better time frames around that in terms of deadlines for responding to patients that currently exist. But I would much rather see us focus on the sort of affirmative availability of electronic information to patients and not happy, separate upon request requirements. So I'm in favor of dropping this and focusing instead on—

Christine Bechtel – National Partnership for Women & Families – VP
Integrating it.

Deven McGraw – Center for Democracy & Technology – Director
Yes, integrating it. Yes, that's a better way to put it. It gets integrated into the portal functionalities that we're talking about, the e-mail communication aspects, the secure messaging that we're talking about. I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Very good. Any other comments to the contrary?

M
... hostels and healthcare providers have to develop a mechanism to authenticate patients?

Christine Bechtel – National Partnership for Women & Families – VP
We're talking to James about getting rid of this requirement by integrating it. So can we hold that part of the discussion until we get to that piece which is probably in a few seconds. But I don't think it applies in this example, because we're not going to require the copy piece anymore. To answer your question, it would have been to do the same thing that you do today under HIPAA.

M
... clarification. This was in Stage1 the EHRs that are certified already have this capability, correct? So we're just taking it out now.

M
We're incorporating it in ....

M
... that, incorporating it into others. But we've already created the functionality to give an electronic copy, which is a good thing.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I think that's right. But I'm not sure how much we actually did in the certification role because I don't think we ever said PDF, CD, US, we didn't, and Alan's shaking his head. I think because this was really a copy of your medical record under HIPAA they could have scanned in and given—well, I guess not because it's ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, moving on?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, please.

Christine Bechtel – National Partnership for Women & Families – VP
The table that you have in front of you is clinical summaries and discharge instructions. There are some common issues and there are some very separate issues, so we'll have to be clear about which we're speaking of. What we proposed for the eligible professionals is you can view and download your health information within 24 hours of the encounter. Then follow up tests that are linked to the encounters but the information isn't available yet are available within four days of whenever they become available to the practice, which is basically what we did in stage one. We said that we would get the Health IT Standards Committee to help us with the data side of human readable and machine-readable.

Let's maybe start with the clinical summary. There was a lot of support for maintaining this as a core requirement in stage one, again, a request to clarify the data elements based among CCR or CCD so they don't have to make a lot of software changes. There were comments about the timeline, so a majority of folks wanted to see the timeline go from 24 hours to 36 hours or 72 hours. I assume, Josh, that that is what they asked for in stage one, which was business days as opposed to a straight hourly requirement. So we have to understand that if that hits over on a Friday, there you go. There was also a request to define the encounters and figure out whether that relates to the data that may have been generated in follow up visits after the encounter but related to the encounter, etc.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so which question do you want to take up first, the time?

Christine Bechtel – National Partnership for Women & Families – VP
I want to do the data elements. That might be easier.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know. .... Okay, so the data elements.

Christine Bechtel – National Partnership for Women & Families – VP
Because we want to essentially—and I think this is our question list for the Standards Committee. If we were to compare the list of information that we have included in the request for comment against what is in the CCR and CCD, which we did a little work with Charlene ahead of time. So it shouldn't be too far off, I think we need to understand what we lose, but as a general rule if it greatly helps to base it off CCR and CCD and we don't lose a lot, then I think that that makes sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We've already had a definition for clinical summaries in stage one, and there's no comment against those, yes?

Christine Bechtel – National Partnership for Women & Families – VP
Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And they're all in CCD, yes?

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I think some of them may be a little bit of market confusion that we're going to have that same. If we agree now on what I've just suggested, then it's going to be the same thing when we get to visit summary and view and download. Then the second issue was the timeline, so people wanting more than 24 hours because of the way that clinicians document at the end of the workday, or we hope it's at the end of the workday instead of during the visit, the 24 hours. It sounds like folks thought that was not enough time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Our previous stage one was three business days, so is that a decent default? Okay. Did the hospitals stand up?

Christine Bechtel – National Partnership for Women & Families – VP
The hospitals, we haven't done that yet. General support for—well, let's break this up. This is hospital discharge instructions, which is different from hospital visit summary. So there was general support also for making discharge available electronically, the instructions available electronically. Folks wanted to have some clarity that that could be through a portal. I'm not sure that we would need to clarify that. I think the real issue here is the measurement. In other words, do you let a ... that is in stage one which is rely on patients to know it exists and ask for it, and then meet their requests half of the time. Or, you actually have to offer it to them electronically. You'd have to tell them this exists electronically, which is again stopping short of making sure they're doing something with it, which in discharge instructions doesn't make sense.

So we had the provider community basically resistant to this notion of offering and we had large patient communities saying, yes, you should offer. So I would say that if we think about wanting the oriented towards outcomes it continues to move down the spectrum toward that way, but definitely stops short of outcomes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One is how do you measure that it was "offered"?

Christine Bechtel – National Partnership for Women & Families – VP
The same way we measured it in stage one, which would have to be attestation, because we measured a lot of other things in stage one on offer, or have the capability. It's the same concept.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if it's easier and moving in the direction you're headed, if we talked, instead of making it available through a portal, and the reason is then obviously everybody has easier access to it, it is in the direction we want to go, it's part of your access criteria. It's clearer rather than just being attestation it's the same thing.

Christine Bechtel – National Partnership for Women & Families – VP
I think the other benefit to that approach would be that it makes the visit summary, the usage of the visit summary separately but also potentially through a portal easy to meet that requirement and easier to get to where we're hopefully going in the longer term, which is usage.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that the end point for us, it's also the easiest way to satisfy all these requirements really, is to make it available in a portal and let people know and then encourage them to sign up. That's sort of the common denominator that would satisfy almost all of these things.

M
Are you suggesting matching to just folks on the portal here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yeah, because otherwise we're going to say, okay, you attest that you offer to everybody. Well, what does that mean and does it change anything versus let's just make it available to everybody and go through.

Christine Bechtel – National Partnership for Women & Families – VP
I think the other thing that we should understand as we talk about the portal is that there were a number of people who said, okay, what about patients who prefer to use a PHR. Which I would say as long as the portal has the download capability, then that works absolutely just fine, although I do have some sort of concern about ending, kind of enshrining today's technology, but that is sort of the answer that we have whatever we name it. Deven?

Deven McGraw – Center for Democracy & Technology – Director
I wonder what about for people that don't want portals? You know, for online banking, I mean, I like the ability to demonstrate that you check this box off by saying I made it available in the portal. But I don't know that I'm comfortable with requiring that portals be established for people that don't want to use them. It's sort of like saying, I don't want an online bank. I'm not comfortable with accessing my bank account on the Internet, but then my bank establishes one for me anyway, but then potentially exposes the account to being hacked, when I never wanted it in the first place. So, I want to make sure that there are provisions, that we're not sort of encouraging portals to be established where patients don't want them and don't access them and then we're asking for an account to be sitting out there that's potentially vulnerable that isn't getting used.

M
And you have the capability to put one out if the patient says they want one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. So, it takes an action by the patient to actually activate their account, but we're asking for the functionality that EHRs provide portal access to this kind of material.

Christine Bechtel – National Partnership for Women & Families – VP
That's right. And remember that in stage one we always said per patient preference, because they should have discharge instructions on paper if they want it and they will get it and that's part of hospital's normal work.

Deven McGraw – Center for Democracy & Technology – Director
I strongly suspected that we were all on the same page, but I think we have to be very careful about how this is worded because people, clearly, from the comments got the wrong impression in many cases about what we were trying to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just one; Charlene.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
On the issue from the hospital, again, a lot of hospitals have not set up this kind of capability for access and many of them have done it, and we talked about it earlier, through the process of their current medical records process. They collect the data, they actually provide the information to a release of information system, the patient goes and gets the access and then they sign on and they "get their portal."

I don't know to what extent those have the provisions for discharge instructions today and those are, in many ways, outside, if you will, an electronic health record. It strikes me what would really help us at least in the near term, that such data is available to whatever "release of information" mechanism is available to get the information. It could be to an HI Indirect, it could to be a release of information system, it could be to a PHR. So, when we start to get prescriptive in terms of is it going to be a portal or

some other means, there is going to be a lot of variety out there and I think we want to enable a lot of variety, with the appropriate security around that. So, I'm just operationalizing it.

Jim Figge – NY State DoH – Medical Director
Can I ask my authentication question?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You would authenticate in the process of release of information.

Jim Figge – NY State DoH – Medical Director
I mean, when are you going to authenticate the patient? Are you going to give them a hardware token like this to authenticate them? How are you going to do it? And when and where?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, where I think it's getting lost a little bit is that remember this objective is different than copy and access. When we talked about this two years ago we actually had a clinical goal in mind, too, that we wanted the EHR to be able to create summaries and that was an important concept in itself. It wasn't just getting information to patients and the discharge instructions encouraging institutions to let patients know what's going on and we didn't care, remember when we discussed it with Neil, it was I don't care if it's paper or whatever; just make sure it goes from the EHR to them. So, as we move to a portal model we may be moving away from the clinical goal, which is to make sure everybody gets the critical information they need, especially discharge instruction.

Christine Bechtel – National Partnership for Women & Families – VP
But what I like about what Charlene is proposing is two things; one, it should still be offered electronically, but we don't specify whether it's a portal or not. I'm open to that idea in no small part because I don't want to lose the opportunity to move this to a core item and I think to make a portal for hospital core right now is not going to work. I think it probably has to stay menus. So, I don't want to lose the ability for hospitals to have to proactively offer things electronically to patients even if in stage two it means they're already using some portal system or they're using some other, or they could use NHIN Direct and health fault, for example, through that partnership, but they could explore multiple ways to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, do you want to restate what your proposed revision would be?

Christine Bechtel – National Partnership for Women & Families – VP
So, it actually would stay the same although we'd probably have to clarify in description kind of our intent, but it would say electronic discharge instructions for hospitals are offered to at least 80% of patients electronically we would, obviously, want to say. They could do that through health fault and Direct or through their existing portal system or through whatever, but this becomes a core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But the measure is attestation?

Christine Bechtel – National Partnership for Women & Families – VP
I think it has to be. I don't see how else you could do it. You offer it to 80% of patients because right now—

Jim Figge – NY State DoH – Medical Director
Well, you're offering it to everybody and whoever wants it will tell you they want it, so why do you need 80%?

Christine Bechtel – National Partnership for Women & Families – VP
Because you have to know that they offer it to everybody because right now, they don't.

Jim Figge – NY State DoH – Medical Director

How is Medicaid going to audit that? How am I going to audit that?

Christine Bechtel – National Partnership for Women & Families – VP
It's attestation, Jim.

Jim Figge – NY State DoH – Medical Director
That the hospital actually offered it to 80%.

Christine Bechtel – National Partnership for Women & Families – VP
It's attestation because right now they don't have to offer it, in fact, they are resisting offering it.

Jim Figge – NY State DoH – Medical Director
So, why would you only offer it to 80%? Why don't you just offer it to everybody?

Christine Bechtel – National Partnership for Women & Families – VP
So, this goes back to the discussions we had, Paul, last year around do you ever have a threshold that is higher than 80%.

Jim Figge – NY State DoH – Medical Director
Well, why do you need a threshold? You author the function.

M
Can I just answer that? Because you're asking people to attest that they're doing it and you're going to force people to lie if you ask them to attest to the fact that they're doing it on 100% of their patients because nobody can ever reach.

Jim Figge – NY State DoH – Medical Director
Well, you don't need to say that. You say our hospital has patient portals and you advertise that, you put signs up or whatever. You don't have to offer it to 80% of the people; you offer it to everybody that walks in the door with various marketing techniques. It might be posters, signs, Web pages, whatever.

M
A common way that I can imagine it will be done is it will just be printed on the discharge instruction form and so I'm not sure what you're gaining versus some other functional or structural way to make this accessible. That would be my comment.

Christine Bechtel – National Partnership for Women & Families – VP
I mean that's the challenge, but I would say a couple of things. One is that is the challenge on every single threshold that we require an attestation to and we haven't raised those issues before—

Jim Figge – NY State DoH – Medical Director
Well, in Medicaid agencies—

Christine Bechtel – National Partnership for Women & Families – VP
Hang on, Jim.

Jim Figge – NY State DoH – Medical Director
They're scratching their heads wondering how they're going to audit 80%. I'm suggesting you take it out otherwise you'll have auditors coming in there asking for proof that it's 80%.

Christine Bechtel – National Partnership for Women & Families – VP
Let me finish and I'll explain what I think the intent is and people can correct me if I'm wrong. The intent is that one way to roll this out in a hospital would be to actually only provide portal access for patients who are getting discharged from a particular department. That's not enough. So, our intent is to get, whether it's portal access or electronic information somehow, first of all, into the hands of patients. But second of all, to recognize that patients don't know to ask for this. So we want to find what we hope—and this is to

Paul's point—would be meaningful ways for hospitals or eligible providers under the portal PHR stuff in the ambulatory setting to actually proactively engage patients to say, you know what, we have this information. It's available now, rather than just turning on a function and not telling anybody about it So, that's the intent. Now, if you have a different way to design and measure that achieves that intent better, I think that's great, but right now that's what we have come up with.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, one way of doing it in the past is by saying that they must provide electronic access turns on the certification process, so that's one good point. In future engagement objectives we have the business of 10% are using it; it seems like that's already enabling this whole measurement of saying, well, you had to somehow encourage people in order to get X%. So, I'm wondering if what we want to do is make sure people provide it and not have this measurement technique that we see an easy loophole, the whole printing on this discharge form and it's not getting on our outcomes and rely on the other function mechanism.

Christine Bechtel – National Partnership for Women & Families – VP
How would we make sure that they are not just turning it on and not telling anybody? Because we already know that the hospitals don't want to tell anybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, but your other function that says you need to have 10% to have already accessed their patient portal, let's say.

Christine Bechtel – National Partnership for Women & Families – VP
I think that's great, but we got such enormous pushback from that from the provider side, although not really in the comments, at least in the summary. So, if folks are okay with going to a usage measure if it's a smaller threshold, I think that's fabulous.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, if that passes can we go; so, one way is to provisionally say this is provide electronic access and then rely on the usage and if usage doesn't pass here then we can come back to this? How is that?

Christine Bechtel – National Partnership for Women & Families – VP
Yeah.

Jim Figge – NY State DoH – Medical Director
Sounds good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, all right. So, now we're changing this to instead of offer you basically provide that functionality of patients to be able to access and discharge instructions electronically.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So, why don't we, just while we're on the topic, even though it's not in order, I don't think, turn to hospital visit summary, which is where the hospital portal comes in. Do you want to try to do that? That's page 47, okay. So, a lot of commenters agreed with making the content available to patients through some kind of online access, again, the same issues around what is the information CCR, CCD, you know, don't lock in in case the patient wants to use the PHR or whatever. Again, some questions about the timing and the timing in this case is within 36 hours of discharge, so nobody, at least that I read, suggested an alternative to the 36 hours and I think our discussions were reflecting the fact that when it's a hospital discharge time really is of the essence. So, I'm not sure what you all want to do about that. And then—

Jim Figge – NY State DoH – Medical Director
In that summary the majority of comments suggested 36 hours is not sufficient.

Christine Bechtel – National Partnership for Women & Families – VP
Right. And what I'm saying is they didn't—

Jim Figge – NY State DoH – Medical Director
They didn't suggest what was sufficient?

Christine Bechtel – National Partnership for Women & Families – VP
Right.

M
There were some comments, but they were one-off comments, so one person may have suggested it, or one commenter may have suggested a week, so there wasn't any consensus and that's why it wasn't included.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So, we have essentially the timing issue here and I think the measurement issues are really the core pieces.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, the timing, 36, that's a day and a half. So, recognizing the intent was to get information, you know, let's say the 30-day readmission, you're really trying to get the patient to their PCP quickly, even within the first week. So, that's like the boundary condition. So, could we do, instead of 36 could we do 72, that's three days, as a reasonable compromise.

Deven McGraw – Center for Democracy & Technology – Director
Can I just ask a question? Can someone remind me of the distinction between what we wanted to have delivered through this portal and the discharge instruction one, where it seems to me that that has really time sensitivity. You know, if I get discharged and there are some things I need to be doing on day one, probably not good for me to get that three days later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The discharge instructions were really immediate. The Joint Commission requires it to be handed, one way or another. So, this is summative information from the admission itself and most hospital do post-process it to code the discharge diagnosis, etc. But yet we want to make sure that all the diagnoses, the meds should be on the discharge instructions, are there and the procedures that happen in a timely way and 36 hours is just a bit stretching it.

Deven McGraw – Center for Democracy & Technology – Director
Okay, so this is really like an equivalent to the sort of summary after an encounter on the EP side, okay.

Christine Bechtel – National Partnership for Women & Families – VP
Although, I mean, Deven raises a good point in that we did not establish a timeline for when you have to offer the discharge instructions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We did say at discharge you have to walk out with it. We did say that.

Christine Bechtel – National Partnership for Women & Families – VP
To offer them electronically, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, does 72 hours seem reasonable?

Christine Bechtel – National Partnership for Women & Families – VP
Are we talking about, in other words, three business days?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, three real days because we're now getting into you want people to be seen quickly because that's how you prevent their readmission, that's how you get the follow-up.

M
So, I have a question about this—because especially I'm assuming there's going to be a data set that we're going to specify for this. There are going to be empty fields because there's going to be some data that's not available even at 72 hours. So is this something that's going to be constantly updated, you check into your portal and five days later there might be a note from a surgeon that wasn't in there at three days? I guess I'm trying to; this is an evolving doc; a discharge can be, if you're pulling data from the record it's going to be an evolving document. There's going to be a lab that's going to come back a week and a half later that went out to a reference laboratory, or a pathology report. This is an evolving document, but you're going into a portal, you're looking at something and it should be noted that, I guess from my perspective you ought to be able to see what's there at any point.

It may not be complete for two weeks if there's stuff that's outstanding, but you ought to be able to go into the portal and see what's available as part of your discharge summary at any point and you'll see today's labs today. You might see the discharge instructions, whatever, but some of the things are going to be evolving and so what we would do is put a statement on the portal that says this is an evolving document. Information that's not available today may be available in the future.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One, we can certainly use the same approach we use for EP summaries, which was as they become available they are updated. But we actually did want to set a minimum data set that was available within X period of time, like all of their discharge diagnoses and the procedures that were done, which they may not have on their discharge notes.

M
This is not my area of expertise, but just from the stuff that I've done in the hospital, I think that this is a very difficult process because it's done differently in the different hospitals that we use. If you send the coding to an outside coder or you do whatever, that's not going to happen in 24 hours or 36 hours and depending upon what type of lab tests you have, they're going to come back in different intervals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, here's what we said, "Inpatient summaries include hospitalization admit and discharge date and location, reason for hospitalization, providers, problem list, medication list, medication allergies, procedures, immunizations, vital signs at discharge, diagnostic test results when available, discharge instructions, care transition summary and plan, discharge summary when available, gender, race, ethnicity, data of birth, preferred language, advanced directive, smoking status." A lot of those things are known.

M
So, I'm just suggesting the "when available" part, which is to say that it's an evolving document and that people should be able to check into the portal and get an updated document; not that there's not a need for a minimum test to be available at some timeline.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, the timeline we're talking about is for the minimum data set and then we didn't include the whole four-day rule.

M
So, is there anything in the minimum data set that's not available directly at the time of discharge?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the code in process.

M
Why would we; I mean, wouldn't they have a copy of their problem list, is that on there?

M
A normal summary is done by coders who go through the chart line by line and that can take weeks. They have a long time before they have to submit that.

M
I don't think they need to code.

M
Well, they add not only codes, they add diagnoses and things that happened in the hospital.

M
Right, and specificity things, too.

M
And that process can take weeks, because they don't have to submit those claims for 90 days or whatever, so that's not going to be ready in three days.

Christine Bechtel – National Partnership for Women & Families – VP
But I think what we're focused on also is what's happening actively in the EHR system or systems in the hospital and how that feeds into the portal in much more real time and at least having that as a start.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And maybe it's time to call the questions; you know, it's not all about claims. You get 90 days to file a claim, but really we're trying to prevent readmissions. You can't wait for 90 days to prevent 30-day readmissions, so we've got to force some of these issues in terms of we've got to get information that's important to the follow-up provider. And Josh wants to say something.

Josh Seidman – ONC
I just to point out that in the earlier discussion, I think back in December about this, I don't think it's clearly noted here, but the patients, it was also meant to include the family and caregivers. Particularly, on the inpatient side, that's of particular importance so that when a family member, when the patient is in the hospital and maybe not accessing the portal so actively, the patient and the family, particularly, remotely can access that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think this is one of those that will be a big step up for stage two because of the need to put the infrastructure in place, the authentication process and those types of things. And kind of back to your point, if the intent is to prevent readmissions, I'm totally for access by the patient; it's just in stage two I think it's going to be tough and there's all this authentication stuff that you've got to put around it. But if it's about to do discharge, I think we're really trying to do that with the exchange of the summary information and that type of thing. So, I guess I was confused in terms of tying that into this requirement and adding the priority to do that in stage two. So, access by the patient clearly is something that we need to enable and that needs to happen, but there's another means to be able to go after reducing readmissions by making that available to the primary care doc through Information Exchange, the two things we're talking about here.

Christine Bechtel – National Partnership for Women & Families – VP
You're talking about the summary care record at transition, which you're assuming would go from menu to core and that's doctor to doctor, which is delightful, but patient and caregiver, too. I mean is there a way to leverage that, the data that's coming out of that summary care record for patients and caregivers?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and most systems have developed those to be the same, if you will. You know, we can send it to the doctor and make a copy on the USB for the patient, but it does not require that portal set, which is basic.

M
How much work is it to fill out the portals?

Christine Bechtel – National Partnership for Women & Families – VP
I think, well, I'll let someone else speak for the hospitals.

Marty Fattig – Nemaha County Hospital – CEO
I think that's going to be a huge thing because we have to do it in a very secure manner and then we have to figure out all the operational issues surrounding it. I think it's huge. And, again, I'm for it. I just want to do it correctly.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So, what if we were to do something that had the portal functionality as a menu item. You could delivery discharge instructions and visit summaries certainly through the portal if you already had one or you were capable or closer, but that we also focused on making information available, so that patients could have a copy of not only the discharge instructions, but also the summary care record, that's transitions that the hospitals have already created. It's a menu under stage one, but presumably would go to corporate stage two. Can we tie that in here? So that we get some kind of information delivery from the hospital to the patient as a core requirement in stage two and then we've really built it out and made it more usable and functional for patients by stage three?

Jim Figge – NY State DoH – Medical Director
I think there's the whole infrastructure that you need to guarantee security and I don't know that we can get that built by stage two.

Deven McGraw – Center for Democracy & Technology – Director
No, it's not complicated. It's really not. It's basically the same kind of security infrastructure that you have for any individual user in your system, you just have to be able to extend it to patients in some way. It doesn't necessarily—

Jim Figge – NY State DoH – Medical Director
Well, I disagree with you because when you put it out over the Internet it becomes a very complicated problem. We've done that in New York Medicaid. It took us 100,000 hours of programming time to build the necessary PKI and all the other structures that we needed. It was an enormous undertaking, and for a hospital to be able to do that is a really big deal. The authentication of a user on the Internet is not simple and not trivial.

Deven McGraw – Center for Democracy & Technology – Director
No, believe me, I'm well aware of that, Jim. We've been dealing with this issue actually in the tiger team and mechanisms to get this done. I mean to use a PKI infrastructure is very complicated. We are not necessarily requiring that as a baseline.

Jim Figge – NY State DoH – Medical Director
Well, but that's what has to be determined, what is the baseline because Medicaid in some states has determined it should be a PKI and this is a Medicaid program as well as Medicare. I think you need input on what does the security need to look like?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And actually the hospitals have an easier out for this because they have the user there in their four walls. One of the challenges is when we don't—

Jim Figge – NY State DoH – Medical Director

They can do identity proofing, right, but then my question was do you give them a hardware token? What do you do to authenticate them as you go forward?

Christine Bechtel – National Partnership for Women & Families – VP
But you do have to do this in order to transmit a summary care record from the hospital to the primary care provider who is outside your four walls, you're using the Internet. I mean I just want to say I think we have to be really careful about our tendency, which I'm going to absolutely call out that we have, to raise the bar when it comes to almost anything that relates to patients and families. To question it and question it in a way that we don't question things for other providers. So, I want to just raise that as an issue and say we have to find a way in stage two, in 2013 when everybody else and their mother on the planet has figured out how to communicate with people on the Internet in a secure way to do something that actually means something for patients. So, I just want to say—

Jim Figge – NY State DoH – Medical Director
Well, it depends on how secure you want it to be. If you want it to be really secure, it's not that easy to do. And I would submit that that needs a whole discussion.

Christine Bechtel – National Partnership for Women & Families – VP
Not in this Workgroup because the jurisdiction is somewhere else.

Jim Figge – NY State DoH – Medical Director
Okay, but then we need to bring that information here to inform us.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And it will.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, so then we have to get to the measurement, I think, issue. But it maybe that what we need to do is; I think there are two paths, as I see them. One is to say portals are menu items in stage two and the measure is usage. The other pathway would be to say that, but also that we have some core requirements that deliver information into the hands of patients and their families and we need a little bit to figure out what that could look like in terms of maybe leveraging the summary, looking at discharge instructions and how are things done today. My concern about simply saying okay, let's do it all portal, even if we have a usage measurement is it's a menu item. Nobody is going to do it and so many patient and family engagement items were menu under stage one that I worry about continuing that. Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I just would say I think it's okay for it to be a menu item, but only if we call it out as a stage three requirement. That the intent of putting it on our list that basically says the intent of making it a menu item now should be clear, that we're calling this out as something that will be required in stage three. We didn't really pick up on Josh's comment, which I want to highlight, which is that this portal should give people access. If I want to give a proxy access to it while I'm in the hospital, this document that's being built with data elements should be available to people even while they're in the hospital and hospitals are putting up computers that patients can access while they're in bed and whatever. I mean, we're talking about levels of safety and information that I think are critical that we begin to work on because after 2015 we kind of lose our ability, at least under this legislation, to make sure that this stuff happens and I think we should start making sure that people are moving in this direction now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, let me just remind us of the statutory authority, so the secretary doesn't have to stop at 2015; the payments stop, but the penalties start kicking in and she has the ability to go to Stage 4 to qualify, so it doesn't end, fortunately. Marty?

Marty Fattig – Nemaha County Hospital – CEO
Just a note that if we do make it menu that does require the vendors to create, to make it happen, so to speak.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think what we're hearing is clearly that's the direction and there are clearly other issues, everything from how to do it, how to do it in a protected way, how to get it to happen in the hospital that we need to work out. But the first default strategy is we make some kind of menu statement so that it gets into the EHRs, so the EHRs have a way to provide patients and their caregivers with access and that's actually fairly straightforward technically and we just need to work out some of these other things before we "require it."

Christine Bechtel – National Partnership for Women & Families – VP
And I think that's right. Again, I'd like to take a minute and figure out how we continue to do something in the core set that gets information into the hands of patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Discharge instruction is not a bad start. It's very timely. There's a lot of information in there, so I mean we do have a start. And then making it required in the EHRs is yet another good start. And it doesn't mean people won't do it. People will do it when it becomes available when they want it to.

Christine Bechtel – National Partnership for Women & Families – VP
Assuming that you evolve the measurement on discharge instructions or are you suggesting keep it the same?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right, that was the other contingency. Maybe you go to use. I'm just nervous that offering is such a weak—

Christine Bechtel – National Partnership for Women & Families – VP
I hear you on that, but the alternative of what we currently have is even worse. So, I think this is one that we may want to think through.

Marty Fattig – Nemaha County Hospital – CEO
I'd be really strongly in favor in the use of portals, not necessarily for discharge instructions because actually it's probably more useful to everybody to have paper going out, to tell you the truth, because you can move it around very quickly, but the whole axis, once we get it into the EHR through our certification criteria.

Christine Bechtel – National Partnership for Women & Families – VP
So, what if we do the secure messaging for hospitals to deliver discharge instructions electronically, which is more instantaneous, again, for patients who want them. But, is that a possibility? So, you're delivering the document electronically, which can be done the same day.

Marty Fattig – Nemaha County Hospital – CEO
And then what would your measurement be? The motivation for usage I think is weaker in that particular instance than just the ongoing care thing.

Christine Bechtel – National Partnership for Women & Families – VP
I mean I would almost say number of messages sent so we know it's in use, we know patients are getting on paper, but we also know now that at least they have some kind of file electronically.

Marty Fattig – Nemaha County Hospital – CEO
So, why even go to secure measure? So, if we go to the electronic access to discharge instructions.

Christine Bechtel – National Partnership for Women & Families – VP
Because it would be menu.

Marty Fattig – Nemaha County Hospital – CEO
Pardon me?

Christine Bechtel – National Partnership for Women & Families – VP
Because it would be still.

Marty Fattig – Nemaha County Hospital – CEO
The discharge instructions are not menu. They're core.

Christine Bechtel – National Partnership for Women & Families – VP
Right, it was a delivery through a portal. I don't see any, "Would require hospitals to send over portal." What they deliver through that portal, whether it's a visit summary or discharge instructions I'm assuming is irrelevant. So, I don't see any way, functionally or politically, that we're going to have portal delivery of discharge instructions be core in stage two. That's my challenge.

Marty Fattig – Nemaha County Hospital – CEO
Okay, so you're saying because we have SBM so far in stage two we could use that as a delivery mechanism?

Christine Bechtel – National Partnership for Women & Families – VP
SBM doesn't—

Marty Fattig – Nemaha County Hospital – CEO
That's Secure Patient Message, sorry.

Christine Bechtel – National Partnership for Women & Families – VP
Oh, SPM, okay. So, again, I'll say again I think that we could think this through offline in a more substantive way, but to look at alternatives like secure messaging or direct and health fault and other things.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so, so far what we've said we agreed on the timeline change for the clinical summaries for AEPs. We agreed on discharge instructions and its immediate availability. We have work to do on how it gets there, to Christine's point. For hospital portals I think we're agreeing to keep it in, but on menus because it's a little immature at this point, but we do want the functionality to move into certification criteria. Have I stated this correctly?

Christine Bechtel – National Partnership for Women & Families – VP
I think so.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we are—what do you want to do about the 80% then?

Christine Bechtel – National Partnership for Women & Families – VP
On discharge instructions?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, hospital portals. Do you want to just move it to usage, 10% or something, as menu?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, good. So we might be at a breaking point for lunch. But let me get a little feedback on the process. I mean, I think we've made a lot of progress. Is this a satisfactory process? Okay. Thank you everybody for participating and following the process and I think we're being productive. We're just a little bit behind, so I'd suggest that we come back at 1:20, which will be 45 minutes. Then we'll resume the patient engagement section. Good, thank you.

(Lunch Break)

Judy Sparrow – Office of the National Coordinator – Executive Director
I think we're ready to begin, if everybody could please take their seats. Okay, Dr. Tang are you ready? Go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Welcome back and we're going to pick up where we left off, which was in Category 2 the patient and family engagement and Christine's in the batter spot.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So, there were two quick things that I thought about over lunch that I realized we didn't address. One is signaling for stage three around portals and hospitals. We had talked at length. I think Farzad had encouraged us before to think about how hospitals could give patients and caregivers access to their health information in real time in the hospital through kiosk portals, etc. So, I think that's something I know I certainly would like to continue to signal around what its importance is. I don't know whether it's best and doable as a menu item for stage two or if it's a signal for stage three, but wanted to throw that out there for discussion. And if there is none, I'll just say menu, stage two.

W
The issues around menu is it has to be developed because you're required from the vendor perspective to have it available, whether it's implemented or not, so it has to be developed, certified and there's this area of possessions that's also around it, so that's a barrier. To get that done in time, I mean it will extend the timeline.

Christine Bechtel – National Partnership for Women & Families – VP
So, let me ask a clarifying question, so we've just come off a discussion where we've agreed that portals should be menu items in stage two for hospitals. Is there a big difference between a portal that's available on site in the hospital for caregivers and they can see what's available in real time, or is there a big difference between that or not?

W
That's a hard one to answer. There are going to be a lot of third party solutions out here to provide access to this and many of them are external to the facility. More of them are becoming accessible within the hospital. So, it's pretty much an evolutionary state right now, so that's kind of hard to answer concretely. But it's really, I think, more about from the EHR perspective, getting that data in in a way that it can be exported to, whatever that media is. The signal is very clear, I think, that this information has to be downloadable accessible, so capturing that information in a structured way to make it accessible to whatever medium, whether it's in the hospital or external to the hospital seems to be what the direction is. And that's what I think is being signaled right now.

Neil Calman – Institute for Family Health – President & Cofounder
I think that there are decisions that are made along the way that are important, again, so that we're not trying to backtrack. So, if you're writing and documenting certain parts of the record that you know are going to be made accessible through a portal, then you might write and document them differently than you would do otherwise. You might set different standards for abbreviations, if you wanted people to be able to see the medications that they were on in the hospital, they might appear differently than they would otherwise. I think it's really critical—to me this is one of the most important aspects of meaningful use is that we're finally sort of recognizing the fact that the record belongs to the patient. That, in a sense, the providers are inputting information into it, but it's really a description of what's going on with the patient that should be accessible to the patient and anybody the patient chooses to make it accessible to. If we sort of had that as a fundamental principle, which is sort of what I always have in my head, then it leads you to different places and it leads you to call things out.

So, what I was trying to say before was if we're saying that there's a portal, we have a standard data set of things that we say should be accessible to the patient, then to me, whether they're accessible during admission, after admission, three weeks after admission, whatever it is, we've created a patient view into their own record. That should be available to them any time they want to be able to see it, if they have a laptop in the hospital or whatever it is, they should be able to access through the portal this standard data set of information, to review their medications that they're on, you know, that they're being given by the staff. I mean we'd like to think that people are being informed about all this stuff, but my dad was in the hospital last week and if he didn't stop the people, they still come and pour the little cup of medications into his hand and he pops them all into his mouth and has no idea whether or not; what? And you know the funny thing is that right at the bedside is a computer and they bar code all of the medication, but then they open it up and dump it into a cup and he still takes it out of the cup and nobody still sits and goes through that all.

So, people have to be able to check their medications and be able to understand what they're on and be; the best nurses tell you when they hand it to you, but the other ones that are in a rush hand it to you and don't tell you. But you still want people to be able to access is and you want family members to be able to access it if that's what the patient chooses to have done so people can monitor that. And every day, he was tracking down the people to try and find out what his INR was, because he came in and it was way out of control and every day it was a struggle to find out what the lab was and why can't somebody just go on their record and look at what their INR is? He's been managing his INRs at home for four years. How come, in the hospital he couldn't find out what his INR was, but at home he has no problem finding it out. So, those are the things I think we need to try to do and I would like to see us make sure that we signal this so that becomes a very clear message in stage three, that it is an expectation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the point is between putting it on our stage three, which we can, obviously, put this on stage three as a signal or make it menu, which is a requirement, which is a requirement essentially that triggers this development implementation thing. I'd almost say stage three because we want to do this and we don't have systems that can do this now, so that would be the reason for suggesting maybe stage three versus the menu.

W
Then as I look at the other requirements about patient portal and you can kind of decouple. The EHR has to collect the data and the data set and have it, but when a patient accesses it, what language and all those other requirements that start to become a factor in terms of patient access, it's a whole other development, some development stuff that I need to do to engage the consumer. So, I'm certainly not speaking against having that access. I think it's going to be critical, but it's just work to really make it work for a consumer, which you don't think about when you develop and EHR, necessarily. Not that you shouldn't, but all that disability stuff we saw in the comments and that type of thing. If you're going to engage your patient and family you've got to think through that stuff. There are products that are emerging out there in the market that are doing that now. I think there will be more as we move down, but I think the focus on making, like you said, that core set of data available so that patients can have access to it, and then we have some tools that allow them to have that access and will take us down that road.

Neil Calman – Institute for Family Health – President & Cofounder
So, we've been asking our vendor to this for years and I think putting it on stage three will help that discussion and we'll want to do it before 2015, for example. I think we can have a special preamble for what we have in this kind of discussion moved to stage three as calling out this strong signal and really getting the vendors, the folks who are proactive to move in that direction, but we ought to have a preamble that says, what do we mean by this? It's not just a push-out. It's a we know that you're not quite ready now. This is our strong signal that you've been asking for about where we're headed. Would that fit? Okay.

Christine Bechtel – National Partnership for Women & Families – VP

Actually, Charlene raised the second issue, which is we had a lot of comments about access to discharge instructions and visit summaries in first common primary languages and what literacy level are they. Now, we've been signaling that for quite a while, so what do we want to do with it in stage two?

Neil Calman – Institute for Family Health – President & Cofounder
We already said when we put this one in for stage two that stage three would include common primary languages, where we did that piece. Literacy is just that much harder, actually.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So, we'll maybe flag the literacy piece as something we need to see some follow-up thinking on. Okay, so the next topic is patient-specific education resources, lots of agreement with this objective and lots of support for not only including it in stage two, but actually increasing the threshold. Folks were suggesting moving it up from 10% to 25%, to a range, 25% to 50% was what the commenters suggested and, of course, moving it to core.

Now, there were some issues around language that we can work on offline, defining what patient-specific means, defining what "if appropriate means," again, the language and literacy issues. Then there were a lot of comments about more accessible formats for delivering them. I'm not sure we want to go down that route, but, obviously you can deliver those via portal or PHR, etc. The one thing, though, that I did see here, that I think we need to ask the Standards Committee for advice on is a couple of folks mentioned a concern they have that the interpretation of the Standards criteria has actually resulted in less patient-specific information. So, I don't know anything beyond that because I'm reading the same document that you all are, but I think that's something we want to flag for the Standards Committee to help us understand. Now, it may be that, I think the HL-7 button info standard, I don't know if that was included in the standards and certification criteria because I don't think it was ready. It is now, though, I think, or closer to.

Neil Calman – Institute for Family Health – President & Cofounder
Well, it's certainly being used by a number of organizations, including the National Library of Medicine in the tool that they have made available to the public. So it's certainly something that's being used. I think there's a question of should there be one specific standard used or not?

Christine Bechtel – National Partnership for Women & Families – VP
So, we need advice from the Standards Committee, I think, on that. So, I think the issue really is what to do with the increase threshold.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A little bit on the history—this is one we had recommended initially. It was not part of the NPRM. We came back at it and it came back as 10% menu. So, that's our history. I think a lot of our defense was the low threshold. So, what we're proposing to do; continue stage one, so this is core?

Christine Bechtel – National Partnership for Women & Families – VP
Well, no, I think it's a menu. Right, so this would make it core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, okay, so then the notation is a little bit incorrect. So, we're suggesting making it core.

Christine Bechtel – National Partnership for Women & Families – VP
Right, and then the commenters were saying that the threshold should be more like 25% to 50%. Now, when you approach 50% I think you may get the denominator issue of not every patient needs patient-specific education resources, but probably something more than 10% might as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, one of our modifiers is if appropriate, which we didn't define. So, one possibility is to remove the "if appropriate" and then just use 10% of all patients and, in a sense, it gets part of, at least in the outpatient world, it would be part of the quote, "after visit summaries," the things that you pass out afterwards. You

would apply the same thing to discharge instructions, which almost by definition should be appropriate for that individual. Now, some of what motivated us was the Joint Commission heart failure instructions that get printed on every transaction and that's what we're trying to avoid really. So, I wonder if we take out the "if appropriate," make that more clear and then have a low threshold, although 10 seems pretty low.

Christine Bechtel – National Partnership for Women & Families – VP
I think that makes sense. So, it would just say, "provide those resources to the patient for more than 10% of unique patients," which would sort of, in some ways, raise the threshold.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Raise the threshold and at the same time clarify it, which is always good.

Christine Bechtel – National Partnership for Women & Families – VP
Yeah, and make it core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now, how do we measure it, though?

Christine Bechtel – National Partnership for Women & Families – VP
I think it's an attestation. I don't know. Can the EHR system print a report of that percent of the patients that were delivered?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It could. They're not programmed necessarily to do that right now. You just do it, right.

Christine Bechtel – National Partnership for Women & Families – VP
Yeah, so, I mean, on this one I'm not sure it's worth doing more than attestation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yeah, and there is a distinction between instructions and educational resources. All right. So, I think what we're doing is we're implicitly raising the bar by eliminating a vague term, a vague qualifier of "if appropriate." How do people feel about that? Okay. All right.

Christine Bechtel – National Partnership for Women & Families – VP
So, next up is secure messaging. This one was very supported, actually, by commenters and there were lots of comments around standards being needed in order to generate, for example, reports on patient messaging, like how many messages and how many were responded to, etc. Some people commented that we might consider focusing more broadly on electronic communication so that you incorporate text messaging, but essentially everybody said that this is a very achievable criteria, and, particularly, with the direct projects security protocols that this makes it even more achievable. So, I think the question to the criteria is patient messaging is in use and the question is whether it should be menu or core, given the high level of support.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think I'd say it's core.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I would probably not suggest that we expand it to SMS; I just think it raises a whole other, particularly the privacy, I think would raise a whole other.

Deven McGraw – Center for Democracy & Technology – Director

I think it's one thing if providers are beginning to use text messaging with patients, but it's another thing altogether to say that there's a federal government imprimatur on sending a text message to a patient when it can't be encrypted.

Christine Bechtel – National Partnership for Women & Families – VP
I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so we're saying in use for core?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great.

Christine Bechtel – National Partnership for Women & Families – VP
Then there was patient preferences for communication; again, lots of support for including this, although lots of issues around how do you define and measure it, what are the options, do you have facts as an option, do you have phone, etc.? So, I think this is something that there's lots of support for. I think commenters would be fine with maintaining it, but maybe need to some offline work to better define it. Then, I think the other issue is communication for what purpose, and figuring out, you know, you have reminders, you have lab results, so you have potentially lots of different ways that patients might prefer to receive information and that's, I think, the other issue that we need to grapple with.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And maybe that's a local decision, right? It could be by your community, by your services, etc. I'm not sure we have to specify those, right?

Christine Bechtel – National Partnership for Women & Families – VP
Yeah, I think what our goal here is to really create the kind of system that collects the right kind of information that allows practices to honor those practices, but we've always tried to respect a line, albeit a fine line, between dictating work flow and local policies and practices, versus what the technology is capable of doing. So, I think that makes sense. So, we probably have a little bit of definitional work to do offline, but other than that I think that's generally an accepted criterion. Then, there's one more that I'd like to raise.

Neil Calman – Institute for Family Health – President & Cofounder
The issue here is sort of the granularity, I think, of the categories, right, which is something that we should take offline because I don't think we've really done that yet and tried to figure out, try to parse those, because the devil is in the details here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And it may be more like EG rather than turning into some criteria for certification. Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
A comment, again from the vendor community, was more like we can't even predict the kind of modalities that are going to be out there in 2015, so do not be too prescriptive. There are going to be all sorts of communication mechanisms.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, so finally, I think, one of the functions that I know the consumer organizations raised that we didn't consider was, as we're giving patients, hopefully, more and more access to their health information, making sure the system has the ability for the patient to flag problems in their data to make corrections or suggest corrections. That there is some kind of technical capability for what basically amounts to information reconciliation instead of MEDREC, you know, we're giving patients all this access. They

know themselves the best. How do we make sure these systems have some way of allowing the patient to say, you know what, that's not correct. Or, you've got the date ranges wrong. I'm thinking of e-Patient Dave and others.

Neil Calman – Institute for Family Health – President & Cofounder
And our PHR didn't have that, but we created that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so the question that I have is how do we get that into the pipeline?

Neil Calman – Institute for Family Health – President & Cofounder
So, I wonder if you create it if they can message about an error or they can actually go in and fix an error.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Message about.

Neil Calman – Institute for Family Health – President & Cofounder
Message about, so the secure messaging is the first sort of mechanism, right, to be able to do that. So, if we're talking about secure messaging we can call out that one of the functionalities there is to be able to message about an error in their record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, what's nice about the way we created it is it, just like other things in the PHR it gets triaged to the right person, so, for example, if you're going to change something in the record it's a licensed professional. In our case, it's a nurse that's making that decision. So, that goes to speak to Christine's point that that functionality; it's just information reconciliation, and maybe we put that in stage three because that's really important, but it's not on the radar.

Christine Bechtel – National Partnership for Women & Families – VP
Right, so maybe if we put it in stage three, but that we explicitly discuss in stage two the use of secure messaging for that purpose and that that is one intended benefit, yes.

Deven McGraw – Center for Democracy & Technology – Director
I'm thinking of the work that the tiger team did on patient matching accuracy and the important role that patients can play in correcting demographic data about themselves that can facilitate accurate matching across providers and institutions so it would be helpful in that regard as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a really good addition. Good, that sums it up for category two. Wonderful. Thank you, everyone, for cooperating with this process because I think we're making a lot of progress.

Okay, we're entering into category three, which is Care Coordination and it really has a lot to do with Information Exchange and who was on point, that's Judy Murphy.

Judy Murphy – Aurora Health Care – Vice President of Applications
Okay, so we'll start out with the first one, which is probably the toughest one, second only to MEDREC; stage one criteria for Health Exchange was perform one test of health information exchange and the proposed criteria is quite a leap from that—connect to at least three external providers in primary referral networks. But outside delivery system that uses the same EHR, or establish an ongoing bi-directional connection to at least one Health Information Exchange.

So, generally speaking, I think this is quite a leap and although there is some support for the leap, I think that the majority of the people are basically saying maybe this is not real doable. Now, from the product development standpoint an or always becomes an and. So, that was my first alert, when I see an or in a criteria it means that the vendors, for example, would really have to develop both because, depending on

the people and how they wanted to implement it, they'd pick one of the other, but the vendor would have to have capability of both.

There was a fair amount in discussion in the comments related to definitions and I think we kind of knew that with stage one, that it was meant to be pretty generic. But as we get into stage two, particularly with the kinds of increasing of specificity as to the type of exchange, some of these things become more important, like what are we exchanging. How is it formatted, what are the data transmission standards, some of which, of course, is Standards Committee work, but certainly needs to be considered in this group. It was somewhat interesting, you know, people recommended alternatives, like opting out, that certain groups would be able to opt out; concerns on the timing, again, that maybe this is somewhat aggressive and the content, itself, or the definitions of the content.

I think when we get into question nine, which was included in this particular one, God and country weighed in on what they wanted to have in the Exchange; we want prenatal summaries, newborn summaries, radiation and chemo dose information, pain scores, airway status. So, we got a lot of pretty specific stuff, in terms of what people would like, probably based on their specialty and, certainly, it's something we might want to explore in the specialty hearing. But I think for the purposes of stage two we really have to think about what we would want to include in this clinical summary. Formatting, again, some comments about not allowing CCD and CCR, but specifying one or the other, probably CCD only; requiring the use of Health Information Exchange instead of making it optional. I think at this point, though, we probably could just open it up for other people's thoughts or comments.

Josh Seidman – ONC
Can I just clarify; so, the Information Exchange Workgroup has sent a letter to you, which you all got, I think, yesterday or the day before. This particular issue is something that they have not yet finalized their recommendations for Meaningful Use Workgroup and that will be coming in a subsequent letter.

Deven McGraw – Center for Democracy & Technology – Director
But I can share what have been the sort of lines of discussion that have taken place on this issue. I think there was, not dissimilar to some of the comments we got from the public, a lot of confusion on the part of Information Exchange Workgroup members. They also read the or as an and, and read it as a potential requirement for people to join HIEs. Which they were under the impression that ONC had previously been pursuing a policy of sort of allowing entities to exchange using the mechanism that worked for them, whether it was their HIE, whether they were using the NHIN Direct protocols. That's the sort of reason for the plethora of models out there.

But the one other point that they made—and, again, that we're still trying to figure out what a more specific recommendation would look like—is that rather than a stand-alone requirement that just says connect to three people, that we think about the different other objectives in meaningful use that really are about exchange of data. Like care summaries, sending care summaries among members of a care team, sending data to patients, e-prescribing, incorporating labs and using the standards and sending labs to public health electronically. That there are all these pieces of exchange that are embedded in, for which in order for you to successfully perform it, you've got to have the connections in place and that rather than thinking of a stand-alone requirement that says, okay, make a connection with three external people or connect to your HIE. That instead we might think about it as what are objectives within the other categories of meaningful use that really we can push for exchange more robustly? Then, that conversation hasn't really come to the point of suggesting exactly what that might look like, but that's the general theme.

Jim Figge – NY State DoH – Medical Director
I will say there are a lot of, well, HHS is certainly counting on stage two to advance information exchange among providers and to the extent that we can do, so it's totally agree with the, let's say, going to lab or there's lots of value in exchange of information. The title of this really is Care Coordination. To do that, it's almost human-to-human.

Deven McGraw – Center for Democracy & Technology – Director

Right, which makes sense, but are there—and I admit I'm suffering from lack of creativity, in part, because I don't have that category well formed in my head—but for transitions of care and moving care summaries among providers, that may be a place to think about advancing that theme.

Christine Bechtel – National Partnership for Women & Families – VP
So, there were 25 consumer organizations that submitted comments and what that letter said was essentially tie it to either the transition of care summary or the longitudinal care record, because the problem with transition of care summary is it's a small subset of patients. We really want to drive exchange more broadly. So the notion that every time I go to a new provider he or she inputs updates into my longitudinal care record and then it goes with me and it can move. That if you took that criteria and then connected it to either exchange through point-to-point messaging, I don't care how you do it, just point-to-point, I mean, security, privacy, yeah, but you get my point.

Or through Direct. I guess HealthVault now has an agreement with Direct, so I wonder if you can go through HealthVault for your patients and then back through Direct, through the NHIN if your provider participates, through a local HIE. I think part of what we want to do here is create the business case for Exchange and so I understand and agree, it can't just be up to Exchange for Exchange's sake. It has to be valuable for both the provider and for the patient. So, the longitudinal care record notion is something that to me has the most broad applicability, although it has its own challenges in defining it.

Jim Figge – NY State DoH – Medical Director
I liked the last two comments. Deven, I wonder if you could remove the public health exchange from the list of examples. Because the idea here is that it would be bi-directional communication and we're fearful that they can't even receive it in one direction.

Deven McGraw – Center for Democracy & Technology – Director
Okay, that's fair. Thanks. We have a lot of public health people on the Information Exchange Workgroup, but I don't remember that point being raised and it's a good one, thank.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I think one of the reasons we put primary referral network in here was to call out differences between the sort of e-prescribing use case and other things to say this is really about coordinating care between different providers. So, I guess I was trying to understand your comments because the other parts are called out in different pieces of our work and this was supposed to be in addition to that, some way for us to signal that we need a way for providers to be communicating with one another.

Deven McGraw – Center for Democracy & Technology – Director
Yes, I think that's fair. I think that, in part, because I think the Information Exchange Workgroup looks at data movement in a larger context, but I don't think that they would disagree that the real point here is to get data moving among providers. I think that they just think that it would be better with a use case attached to it as opposed to make a connection with three providers and a test that you've done it. I'm not sure where that goes, but, again, this is, obviously, up for discussion. Their focus is on exchange policies to facilitate data exchange and they're very much as eager, as I think we are to sort of push that really strongly in stage two and just try to think about what's the right way to do that.

Neil Calman – Institute for Family Health – President & Cofounder
So, just to follow up on that, the point that I was trying to make is that we probably should build exclusions into the other three so that it doesn't just become, oh, I meant the three by doing e-prescribing, because otherwise we're not really making any progress through this particular piece. And I think there was an intent to kind of move people towards some kind of exchange. Because what we're saying is there's no quicker way to realize that point-to-point exchanges with three different people that you're going to sit down with and try to develop protocols with doesn't make sense and it either moves people toward sort of

a direct kind of protocol or working with a formal exchange. I think that was the intent at this point, to try to move people in that direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sometimes they talk about the MU criteria as being an "excuse" for doing what you want it to do already or for doing the right thing. And maybe we can apply that to this one as well. Our goal is to not say let's be arbitrary, I want you to do these following things; rather to say, look, pick on someone who you, obviously, already want to exchange with and just do it. So, I don't know that the number three, because three might actually be having this unintended effect. We really want you to get information from one human professional to another because it's in the best interest of patients and maybe we just say that. Because it clearly is on the right track, but, if we start conditioning it, we end up with these unintended side effects.

Christine Bechtel – National Partnership for Women & Families – VP
I guess two things; one, is if you're saying really all we're saying is connect with one other person, that's not going to work. In stage two that's supposed to be about information exchange; it' just not going to look good. I mean it's not enough to just connect to one other doctor point-to-point.

Neil Calman – Institute for Family Health – President & Cofounder
It's on the road. Why wouldn't that be on the road?

Christine Bechtel – National Partnership for Women & Families – VP
Because they already do that. They did the one test of the a certified EHR technology, so they figured out, well, I don't know if they figured it out that the test didn't have to be successful, but nonetheless.

Neil Calman – Institute for Family Health – President & Cofounder
Well, we said test; it really ended up being a test of the functionality, not a test of actually exchanging information. So, most people are getting out just by testing the functionality in their EHR. And so, I think what we're saying is, okay, now use it to do something that you already needed and wanted to do and, in a sense, given them credit for that. And that's sort of, I think the general philosophy we have.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But, in my view that make stage three about information exchange, not stage two. stage two can't possibly be about information exchange if it's one person doing something with one person and they stop there and I think your hypothesis is they won't stop there and I'm just sure I agree. But, are we getting a letter then from the Workgroup and should we wait for that to make decisions, because I think that would be helpful.

Deven McGraw – Center for Democracy & Technology – Director
I don't know if I would totally hold off on refining this. At least the last meeting that we were in, they were actually looking for, I think, not having a separate category that says connect with a person, two people, three people, but rather building the robust exchange requirements through a use case, like the sharing of a care transition summary, for example. We may feel differently, but that's the direction we were headed into last time and I think it might still be worth either putting this one on hold as is. I think we all understand what the purpose of this; there seems to be no disagreement on that from a consensus standpoint, but in terms of what, if anything, needs to be done with that category, I guess we might want to wait. My longwinded answer to say, yeah, let's hold off. But as we progress through some of these other exchange measures, we might keep that in the back of our mind about whether some more specificity with respect to those might actually do what we want.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I just was going to add the clarity around, again, operationally, when we thought this through at the beginning and talked about it, the pushback from the provider community was well, what if a doc isn't automated or what if an HIE is not in town, so we backed off to do the test. So, in the conversation this is the next step, that I can at least now take that step and connect to maybe that automated practice, or that HIE if it comes in town. So, again, it always assumes the use case, I think, of transitions of care. Now,

maybe we weren't explicit in that, but there was always that intention behind this one. It was just creating the pathway to get there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Marty and then Christine.

Marty Fattig – Nemaha County Hospital – CEO
I believe that this is one of the ways that we gain the most benefit from everything we're trying to do is by connecting us all. The problem I currently have in our location is finding anyone to connect with that even has an electronic health record in place, especially the tertiary care facilities, to which I transfer patients. So, I just want us to keep in mind that it is imperative that we bring as many people forward in stage one as possible so that this has maximum benefit because, as I say, initially, this is where the real value comes forward.

Christine Bechtel – National Partnership for Women & Families – VP
I just want to say one of the challenges I think that we have is remembering that we're talking about two years from now. So we have Direct in, what, five states, five communities; so two years from now if Direct really accelerates we could have a very different exchange environment by the time these criteria actually get written and it could be more like secure messaging where you just say you need to be part of direct. But I just want to remember that the environment is advancing pretty rapidly.

Judy Murphy – Aurora Health Care – Vice President of Applications
I'm thinking we need to reconcile this particular criteria with that summary of care record criteria between eligible providers. Because it not only gets at what Deven was talking about; this criteria that we're talking about right now is really the only one that hospitals have to do, but the summary of care record between EPs was a menu set criteria. If the recommendation of both the HIE Workgroup as well as from the comments was to bring that one forward and probably take it from menu into core, maybe we've resolved some of the issues, at least between EPs for what the conversation is here. Then we would just really have to deal with hospitals because eligible hospitals were not covered in that current menu set criteria. It's one of the ones that was EPs only, but if we could think of a way of taking that same criteria and applying it to hospitals rather than one test or jumping all the way to HIE connectivity.

Part of my concern is, although what Christine says is true, we're thinking about two years from now; not really, because the vendors need this criteria, or will have this criteria about one year from now and have to bake it into the products so people can install it and start a testing in October of next year. So, it is a little timely, but I think we should talk about that summary of care record probably almost at the same time because I do see overlap with these two, and then talk about HIE connectivity. It's almost a separate issue. Because first we're just talking about exchanging information and using NHIN Direct, as an example, is not connecting to an HIE. They are two very different things and I think that was pretty spelled out in the letter, too, that we got from the HIE Workgroup. They're not specifically suggesting HIE connectivity.

Josh Seidman – ONC
I have a question on this use of clinical summary exchange, because our clinical summary objective just talks about the ability to spit it out, not necessarily transmit it electronically and the reason for doing that is we want all patients to be able to have that no matter what. If you want to link the two directly, then we get into and how do you measure it and what percent because we really want 100% to have clinical summaries to go with them. This is a separate objective, to transmit information electronically.

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, the recommendation from the Workgroup, which I just saw myself, is "provide a summary of care record for more than 50% of transitions or referrals or 30% of those transactions," they should be transmitted electronically. So, it's 30% of 50% as I'm reading and maybe you guys could tell me if I'm reading this correctly.

Josh Seidman – ONC

You're reading the same thing I'm reading.

Deven McGraw – Center for Democracy & Technology – Director
You are. There was a lot of complicated math that went into that, but you got it right.

Judy Murphy – Aurora Health Care – Vice President of Applications
But at least it's addressing, I think your specific question right now, are you just generating it or are you also transmitting it electronically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But aren't we, the more complex it is, as we found out with HIPAA, the less it's going to be done? So, having to do the math to calculate; we really should just point people in the direction that they need and want to go instead of making it really complex to satisfy an administrative reg. I mean, that's one philosophy.

Judy Murphy – Aurora Health Care – Vice President of Applications
Paul, I actually agree with you because I'm also on the Implementation Workgroup of Standards and I've got to tell you, the last two hearings we had, the same consistent message was, just tell us what we have to do, and don't give us options. I mean, seriously, it's kind of like just tell us. And so all these data interchange options and stuff are confusing people and not making is simpler.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It seemed like when we went through the role-making process we had and, again, my intention or thought process was, this particular one, was the mechanisms to exchange the care record summary or whatever we're calling it. I'm probably going to get the wrong name. Then through the CMS process they added another line item to produce the summary of care. The intent seemed to be the same thing. They were overlapping and I think we've struggled a little bit with the fact those two overlap, so if we could think of things; the provider-to-provider scenario and then the provider-to-patient scenario that target in the source and maybe break those up a little bit and that might help us think through this a little better. So, provider-to-provider, we want to do that with this objective and we want to eventually do it electronically and we want to, because we did the test, we want to build it out in stage two in some way. At least that's the case I thought we were on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think you're right. This is care coordination, which is the communication and sharing of information amongst folks involved on the professional side of this patient's care. And I think we need to move things, electronic, begin moving in that direction, and that's the target of this particular objective. Does that make sense? It does not in any way dilute the clinical summaries that go to everybody as an output of patient engagement.

Judy Murphy – Aurora Health Care – Vice President of Applications
Right, absolutely.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But I'm not sure it's helpful to tangle it up, in a sense.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yeah, no, I don't think it should be tangled, I think it should be separate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And create different percentages.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so now we're getting closer. So, now the challenge then; now, I understand the or for vendors. I think IE may have interpreted this wrong. It's not an or for the provider. The provider does one or the other and satisfies it. They decide how that's best in their community. Now, is one of the major the three? Okay, so let's see if we can't deal with that one right now. I mean three came across because it was more than one, less than ten.

Judy Murphy – Aurora Health Care – Vice President of Applications
But they're not even doing it with one, and so maybe that's one suggestion we should put on the table.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. I think we just do one because whatever is in your best interest. Connect, exchange information for your benefit.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, my fear is that takes in the wrong direction because you have somebody who basically to meet this tries to do some one-off with somebody to exchange information. That's exactly the opposite of what we want people to do. The reason we called out three is because doing three of those is more work than hooking up with an exchange or whatever. So, I think we need a way out, but I don't think what we want is somebody to sit down and go, like, let's just figure out how we can swap data through some protocol that we're going to sit down with your IT people and develop.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, we certainly can specify NHIN Direct.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay, we can do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, and Standards would certainly do that, right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, they would have to use that in order to do their one test?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, not one test, I think we're saying one production exchange.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The production use. And actually, it's possible we can project forward. I'm guessing, I'm hoping NHIN governance would have certain rules that ensure the interoperability. So, both NHIN Direct plus the HIEs would have to follow whatever the standards of protocol for exchange would be.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Suggesting what here and what here; here I'm pointing to HIE test, that evolution versus summary of care record and that evolution and why we are not just moving it to summary of care. I don't see why we're stuck on test HIE as an objective that we need anymore. It's just this is the outcome. Why not just move to the outcome?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's totally fine.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The outcome is remote care being transferred among providers.

Judy Murphy – Aurora Health Care – Vice President of Applications
No, I'm kind of there, which is why I was linking the two because I think what you're exchanging is a CCD anyway.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, delete this one because we tested it. We got it into the product and now we're going to use it here, so use the word HIE under summary of care record. They're just following the HIE's letter.

Judy Murphy – Aurora Health Care – Vice President of Applications
But we'd have to expand summary of care, George, I think to include the hospital. So, when you were doing your examples before you said EP to EP. Well, it could be hospital to EP or EP to hospital.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think that summary of care got added later, so I think we had thought summary of care was embedded in this one. So, I think you're right. If we're going to take this one and move it down to summary of care we need to expand the hospital and make sure it's the same thing. We don't change it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, we get credit again for reducing the number, by using the trick of integration.

Christine Bechtel – National Partnership for Women & Families – VP
How is the summary of care record different from a summary of a hospital visit that goes to a patient?

Judy Murphy – Aurora Health Care – Vice President of Applications
Because there was not a strict definition evolved by anybody on summary of care, no one knows. For our sake we're putting into it what we think people want, but there was no definition. Now, again, there were a fair amount of comments that maybe we should have a definition, so that's, again, something we could either handle or bump to Standards because we may want to say it minimally should include these things and have a minimal set and then, of course, whatever else. But I know, this is a really helpful thing because hospital to hospital is important, just like EP to hospital and hospital to EP and whatever other combinations for care coordination because a lot of people are referred from us tertiary care to primary care and vice versa, yes.

Christine Bechtel – National Partnership for Women & Families – VP
So, it seems to me that if really at the end of the day what we're talking about is a CCR or CCD or whatever it is. We're talking about that for a summary care record, but we're also talking about it for the hospital visit summary and we're talking about for the EP side, I mean let's get the thing and then move it. Well, then you've got to move it and the issue is you've got to move it to another member of the care team, which hopefully is listed in that document. We'll get to that later. You need to move it to patients and their caregivers and then you need to move it to other providers and then potentially to public health if they need it, I guess.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Well, then it becomes other versions. The CCD was intended for, I think, caregiver-to-caregiver exchange, but it may not meet all the requirements for caregiver-to-patient exchange or caregiver-to-public health exchange, the different variations.

Christine Bechtel – National Partnership for Women & Families – VP
And doesn't meet for setting, too, it's fairly setting specific.

Neil Calman – Institute for Family Health – President & Cofounder
So, does the CCD have a field that would say I'm referring this patient to you because they've had three days of abdominal pain and I'd like, what?

Christine Bechtel – National Partnership for Women & Families – VP

It's more specific; we have that data chart, right? Do you have that one. But the intent I don't think is there.

Neil Calman – Institute for Family Health – President & Cofounder
That's the difference between care coordination and sending a summary, just to be very specific. The difference is the ability to communicate a direct message to somebody that has the qualitative feel to it that says here's what's happening and here's what I need from you and there needs to be a way to connect that somehow to this document, this summary document. So, I don't know where that happens, but from a clinician's point of view, that's what you want to read when something is coming across. Just having a document is not going to tell you why you're getting the document or what you're being asked to do with the document.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So the use case now, like the Direct case we're working on is at discharge you send a summary of care record or the CCD to the primary care practice and, again, that's for the intent of MEDREC and all those kinds of things in follow-up. That's what we're working on.

Neil Calman – Institute for Family Health – President & Cofounder
Go back to your doctor; that's the easy one, but the other direction is much harder. It's when you're sending somebody to an emergency room for an evaluation or to a specialist for an evaluation or the specialist is calling you to say, you know, is trying to signal you to say here's what I found and here's what I think you should do to follow up. We need that kind of messaging built into this somehow. I don't know how that happens.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The NHIN Direct project done by John Blair and MedAllies in the Hudson Valley does exactly what you're talking about.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, we need to input into this.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But you could take that as a model because they've built all those components in there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now, there is a little caveat here. Summary care record, again, is something that gets produced and that contributes to the care coordination and we set a pretty high bar, 50% and moving it to core. We would then complicate this objective by saying and X number have to go by electronic. So, just from a visibility, understandability, it may be helpful to separate the two, just like we did previously. Does that make sense? We're moving the field along, the whole escalator thing; so, we want certain minimal information to go from one place to another to contribute to care coordination and we want to start people on the escalator to move it electronically. So, I'm not sure consolidating the two is helpful to our cause because we'll just get hung up. Does that make sense?

Judy Murphy – Aurora Health Care – Vice President of Applications
It does.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, right now they're still separate. Let's talk about them. Where do we end up with HIE? So, Neil was pushing for three because we wanted them to get the feel of exchange. I think you accepted the if we had a standardized way, like compliant with Direct, or compliant with NHIN governance protocols and standards, that would fulfill your need. So, the motion on the table is to remove the number three and make it go from one human, so one provider to another and not to count—and Neil's point also is—and not to count ERX and those sorts of things as part of this.

Judy Murphy – Aurora Health Care – Vice President of Applications

There was one other thing in the definition that might be helpful related to this. It had to do with the primary referral network, so we might want to still use those words meaning that we're doing it within a referral network, which would infer there's a reason for doing it, and not just willy nilly deciding to do it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What we can do is put that in the preamble and then they understand what we're trying to do, but not have everybody ask us, well, what's a primary referral? Who certifies my primary? So, okay, I think we're; no, not yet, okay.

Christine Bechtel – National Partnership for Women & Families – VP
And maybe I get overruled here, but I just am really stuck on the one-to-one idea. I'm thinking if Direct is ready and it requires ONC to tell us how ready it is, why wouldn't we simply say you have to participate in Direct if it's in your state? Or an HIE.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There's HIE exchanges and all sorts of other models.

Christine Bechtel – National Partnership for Women & Families – VP
Great, fine. That's fine. But, I mean, the one-to-one or one to however many, it should be; I don't think that option should be available if you have HIE, if you have Direct, if you NHIN, if you have others.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, we took that off the table. We already took that off the table. You're either Direct or HIE compliant with whatever NHIN governance decides.

Deven McGraw – Center for Democracy & Technology – Director
But I think Christine's point is if you have a way to exchange by either one of those mechanisms there's no reason to stop at one, because the mechanism is in place. Because Direct is not state-specific. It's a set of standards and protocols that anyone in the nation can use because it's based on secure messaging. So if you don't have an HIE in your state or you don't like the terms that the HIE is offering you and you want to exchange directly, that's fine and because all of that, again, Direct had just kicked off, but AAP launched a partnership with it. I think that to limit this to just one sends a really bad signal given that we actually have done a fairly decent job of priming the pump here.

Neil Calman – Institute for Family Health – President & Cofounder
Okay, so the point is we're not limiting. So, one of the pushbacks is what if you can't find three willing partners? Why do we want to get hung up on that issue?

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure there's a number here, period. Let me take it from a different angle. Why would we not simply; we are saying you need to use secure messaging with your patients. Why would we not say you need to use secure messaging with other doctors? And if you do it through direct, then your criteria is—

Neil Calman – Institute for Family Health – President & Cofounder
I think that's exactly what we're saying.

Christine Bechtel – National Partnership for Women & Families – VP
But not with one, I mean, right? So, that's my challenge.

Neil Calman – Institute for Family Health – President & Cofounder
The one becomes irrelevant because you're either connecting through; we're saying you can meet the criterion by doing an NHIN Direct type connection or an HIE type connection period.

Christine Bechtel – National Partnership for Women & Families – VP
Right, but that means everybody who is a meaningful user is either on secure messaging or they're part of an HIE, so they're going to have a much, they should; I mean, there are more than two doctors in a

town in any community, I'd hope, in this country that will be part of meaningful use. So, if you say, you're either doing secure messaging or you're part of an HIE, whatever exists in your state, they de facto have a lot more trading partners than one that they should be able.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But just for measurement we have to say either all or some.

Christine Bechtel – National Partnership for Women & Families – VP
I'm better with some; it's more than one or three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, but when CMS has to actually tally it they either say one or more or something. If we say some, that's one or more to CMS. So, that's where they ended up with the one; not that they want to limit it to one, it's just they had to pick. So, let's not use the number and say there is exchange existing. Now, we're saying it's all, but all is hard to measure.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Can you just say at least one?

Christine Bechtel – National Partnership for Women & Families – VP
I think it sends a terrible signal and I will not say this after this one time, but I think it sends a terrible signal. This is supposed to be stage two, the era of information exchange. We were supposed to have done the one already and so the notion that even just saying at least one, because that's all we can count, that is not the message that people are going to take away from it. They're going to take away the message that, oh, the market is not mature enough, Information Exchange is not ready, there's not a business case and I think that's a bad message to send. So, I'm happy for people who know this space more than I do to take it over, but I'm just really struggling.

Jim Figge – NY State DoH – Medical Director
If you're able to do it once, there's nothing to stop you from doing it multiple times. I think the point is you're demonstrating that you're capable of doing it.

Deven McGraw – Center for Democracy & Technology – Director
I don't want them to demonstrate capability. I want them to do it. I think that's why I like the idea of building the exchange into the actual use case because that we can count. So, share a summary of care record electronically for some X% of your patients. It hits it without us saying at least find one of your buddies to agree to take a piece of paper from you.

Judy Murphy – Aurora Health Care – Vice President of Applications
You do have to find a buddy in NHIN Direct. I mean NHIN Direct is not a broadcast. It's not a, hey, I'm going to send it out there for anybody who wants it. So, you do have to have an agreed upon, pre-determined partnership. I'm going to ask you for stuff periodically and you'll send it to me and you're going to ask me periodically. That, in itself, infers that there is this pre-arranged agreement. It's not a broadcast. HIE is a lot more like a broadcast, so to me, I like the at least one, and I think that infers, as Janice was saying, if you're doing one, you have the capability of doing multiple, but they have to have one in production, not just demonstrate, not one test, one in production.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And logically your preference, if there was an HIE or Direct there, that's what you would go to because it would be easier than the one-off case. I mean, you don't want to do the one-off case.

Jim Figge – NY State DoH – Medical Director
Well, we're taking the one-off case off the table. It's either Direct or a sanctioned HIE. And if you can do it correct with HIE and you've done it once, you're going to keep doing it because it's a lot better than faxing and all that. I mean I don't see what the problem is really.

Christine Bechtel – National Partnership for Women & Families – VP
And I'm not sure, Jim, if I'm saying the same thing as you are because I might pass out, but I think I am, which is if everybody in Sheboygan, Wisconsin has got, every meaningful user, has to either do Direct or HIE, then one should be, that's like a no-brainer. I should have 30 buddies; I just have to find them and I have to talk to them and say I want to exchange. It gets me back to defining the referral network.

Jim Figge – NY State DoH – Medical Director
I mean, when you start setting arbitrary numbers then, again, you've got this audit issue. I think the point is you're capable of doing it and once the clinicians figure out that they can do this, they're going to want to do it. Trust me. They're going to be banging at the door to do it because it's a lot better than anything else.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, so we're not saying the same thing, I feel better.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me see if we can get agreement on at least one.

Neil Calman – Institute for Family Health – President & Cofounder
If we can just phrase it some way, if at least one is what we mean we don't want to emphasize the one because we don't want them to stop at one, so maybe in our preamble we explain what our intent is, which is what Christine is saying, but I don't think we should count three. So, I'd say at least one.

M
You don't need to say that. Make it a requirement, it's by definition—

Neil Calman – Institute for Family Health – President & Cofounder
Just saying must exchange data with a trading partner, either through the HIE and in Direct.

M
Here's a work around. If you want three, then you find three docs, and you send one document a year to three doctors and you're done. You've met meaningful use and you've accomplished nothing clinically. As opposed to if you link to on doctor and sent all your documents, you're probably doing something more useful. So, the way we measure it is not the point. We want to get things going. I agree with Deven, that's why I was seconding that, that if we could get to the clinical metric, then at least we can measure 10% of that, but if we're not ready to go there yet then I say we just have some and whether we say one or three, you can always game the system.

Christine Bechtel – National Partnership for Women & Families – VP
But I think the clinical metric is the right way to go. I mean, why can't it be, look, if we go through the criteria in draft and understand where change is required, not e-prescribing, but longitudinal care records, summary of care data, I mean transitions of care, you know, blah, blah, blah and we say you need to at least report the number of documents, the number of transmissions. I mean, that's not ideal, I'd rather have a threshold, but there needs to be a clinical relationship here because it gets us more of an ability to measure.

Jim Figge – NY State DoH – Medical Director
You're adding a reporting burden that's unnecessary. I think the bottom line is that the clinicians will want to do this. If I, in my own practice, can send something to somebody electronically that happens immediately than if I have to fax something, you know, we have to print it out, fax it and then the receiving doctor has to scan it back in, it's a lot more work to do that. It's so much easier to send it through an HIE, so I don't think this is a real concern. I think counting the numbers of documents and so on is just an unnecessary reporting burden.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me try to edit the final rule; so the final stage one, “Perform at least one test of certified EHR technology’s capacity to electronically exchange key information. Proposal for stage one: Use certified EHR technology to establish an ongoing bi-directional connection with an external provider.”

Christine Bechtel – National Partnership for Women & Families – VP
You’ve got the and in there.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Just one? We’re back to—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I didn’t say that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
She said “an external provider.”

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
An external provider.

Neil Calman – Institute for Family Health – President & Cofounder
Using either HIE or a NC Direct protocol. That’s the key.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We’re just going to end up asking for clarification again.

Neil Calman – Institute for Family Health – President & Cofounder
Right. If you use the plural, they’re going to say how many?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, how many.

Neil Calman – Institute for Family Health – President & Cofounder
So, that’s two. Do, do you want to say at least two, because if you use plural they’re going to assume it’s two and if you use singular, they’ll assume one.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think “the ongoing use of bi-directional exchange of information electronically is on the escalator in the right direction.

Christine Bechtel – National Partnership for Women & Families – VP
I’m arguing that it’s the bottom of the escalator.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, well, let’s vote then because I don’t think we’re going to get 100%.

Judy Murphy – Aurora Health Care – Vice President of Applications
And the only other thing is to add hospital; you said provider, so we have to use hospital.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, and I think the other thing is does this have to be with another meaningful user? I mean, what if you can send transition of care documents to your nursing home? And important place for a transition of care document to go.

Christine Bechtel – National Partnership for Women & Families – VP
Or visiting nurse.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so let me try again. "Proposed stage two – Use certified EHR technology to establish an ongoing bi-directional connection to an external clinical partner (provider, hospital, nursing home, etc.). Oh oh.

Christine Bechtel – National Partnership for Women & Families – VP
It's better than this and why don't we start with that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We'll wordsmith that, but we've got the concept.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so do we have a vote?

Christine Bechtel – National Partnership for Women & Families – VP
Well, are we going to keep working on it? If we are, I mean, if this is the thing that's going to go to the agency, then I have an issue. But if we're going to use that as a starting point and keep working on it, I'm not sure we need a vote.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I think the vote is on the use of the word, "at least one" basically and figure out how to say it.

Christine Bechtel – National Partnership for Women & Families – VP
So, we've taken off the table connecting it to a clinical use, like a use case.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know many people that would want to do this without it being useful to them.

Christine Bechtel – National Partnership for Women & Families – VP
Right, but it gets us a different measurement and it gets, in a sense, a different signal than an external provider or a one or a count or a number, right. So, it's not just establish a bi-directional communication channel, that you may or may not use.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so then I would consider we can do this by wordsmithing, but I think what we're voting on right now is the at least one and I think we can wordsmith the rest, so I think we need to vote. All in favor of that one, at least one? Okay. And then we'll wordsmith it to make sure that we can make sure that clinical information exchange. How's that?

Deven McGraw – Center for Democracy & Technology – Director
I think it's a completely ridiculous objective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, we'll come back to it.

Judy Murphy – Aurora Health Care – Vice President of Applications
That was so much fun, let's talk about MEDREC. Because it's equally as much fun. So, I think in terms of medication reconciliation, the three points, three of the four points that are listed under the key points really summarize all the comments and it's the second, third and fourth ones, so the majority of commenters recommended the objective be moved to core without increasing the threshold.

And I supposed I should go back and read the criteria, so, "It's a menu criteria today and the menu criteria is to perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the inpatient or ED." So, again, the majority of comments are suggesting that this be moved into core, without increasing the threshold of 50%. The comment right below that, "Majority of comments requested clearer definitions around care transitions and relevant encounters and I know that numerous folks, including myself have struggled with this one,

so I think some clarity around that would make a lot of sense. And then aligning it as we clarify the definitions with the Joint Commissions requirements, which we're not out of sync with either, but I think to make sure to say that we are in sync with those and using those as a base would make a lot of sense. So, this one is maybe actually easier.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so one of your questions is care transitions and relevant encounter definitions. I can tell you the relevant encounter became a way to make it less than all encounters, but it was ill defined at the time that we used those words, so almost being better about care transitions definition would be useful.

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, I think some of the clarity also was required around ICU to a general med surg unit, as an example. Some folks thought that was a transition to care when by definition, is it really?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, we talked about care transitions as being a change in site or provider, I believe. And the only thing we could clarify is, yes, changing from one unit to another in a hospital, I mean you have, literally the orders have to be rewritten, so that's certainly a care transition, different players, different teams. So, if we extended the site definition to include units in the hospital do you think that would cover it?

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, there's the surgery thing because a person could go from a unit to surgery and back to the same unit, so that's another area, I think, that has been at question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, in that case you rewrite; there's three sets of orders going on.

Judy Murphy – Aurora Health Care – Vice President of Applications
I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, I would say every time you go to a different unit in the hospital.

Judy Murphy – Aurora Health Care – Vice President of Applications
I think just with the definition we should clarify those points.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Judy, so is the point that you're going to add those in? Because I think the intention was always, if you will, at least where we started was venue-to-venue, not within a venue. So, if you do add within a venue that, not that it shouldn't happen, but that really raises the bar in terms of MEDREC.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It also catches the errors.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I'm agreeing, but it changes the whole intent from where we started.

Judy Murphy – Aurora Health Care – Vice President of Applications
I think that question has been out there anyway as people have implemented this criteria, questioning whether or not it should include those. And I think just adding the clarity, I would recommend that it does, too, just personally as a clinician, but I'm not sure if everybody agrees with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And the reason for me mentioning the different order sets it that it clearly would imply that all of the teams and the hospitals agree that you can't just pass the order on to the next unit and expect it to be relevant.

All right, so I see a lot of head nods on that one. So a further clarification that change in site includes change in unit within a hospital, okay. George, here we go.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm just worried, but keep going.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, we have a worried George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's just what's the change in unit, do they change bed in a room, do they change rooms, do they change a unit?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We could even say it's the nursing unit, that probably would fit. Then relevant encounters, I believe, talked about the outpatient area and I think we probably can carry it with provider or specialty. I'm seeing some nods. Other disagreement with that? So, if there's a change in.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well, you're going back and forth between providers and you would like to know what meds are going on between them. They're not on HIE yet, but we can't have every time, to do another measure. Maybe, every time you change medication you want to do a med; that's not enough, but it's a bare minimum. Every time you change the medication for a patient you'd certainly want to be thinking about.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What about, there is a concept called transfer of care, so when you go to a consultant, there are actually two CPT codes. One is you consult, you give me advice and then I go on taking care of this patient. The other is you transfer the care and that person is managing that particular ailment, like diabetes. In that case they have an ongoing responsibility and so the back and forth, we're not going to capture all of the scenarios that's for sure, but every time we make this transfer of care, which is, I guess, the outpatient equivalent we would do a med rec.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If you have community-based providers and people are going to a consultant and back, you're not going to be able to really trigger that, I think, to be able to review it. In other words, you're sending somebody out to two or three consultations and the consultant reports come back at different times, you're seeing the patient at different intervals, you know, how would you decide which of those?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's how we came up with the term relevant and what we did was we said relevant is in the eye of the beholder or the receiver. And maybe we can stick with that and explain that's what we meant because of these things. I mean, really if you're sending somebody out and you want to come back and make sure, so the cardiologist prescribed some new antiarrhythmic, I've got to know and I've got to put it on my med list, especially if they're not on my EHR. So, in a sense, that's why we ended up there. So, I think they're asking for clarification and it's also true that the final rule came out with certain things that said, well, you define what this means and I think that's feasible.

Judy Murphy – Aurora Health Care – Vice President of Applications
I'm only smiling because 80% of the comments asked for, "A clearer definition of care transition and relevant encounter."

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, we did pretty well on the transition. The relevant encounter, I think we have to explain ourselves.

Judy Murphy – Aurora Health Care – Vice President of Applications
The intent; I think if we explain the intent again.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Part of it is how could they interpret relevant encounter when they didn't understand how we go there.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, what did we went up with?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For care transition, so, you're coming from one PCP to another, transferring care, that is clearly a transition. As far as going to specialists and coming back, it's up to the receiving provider to decide whether it's relevant to do a medication reconciliation. Now, how you measure 8%.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay, so they transitioned into the care of the EP and that's what we're sticking with. We're saying we're sticking with stage one's definition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct, but explaining our intent.

Judy Murphy – Aurora Health Care – Vice President of Applications
So, that they can better determine the definition of relevant.

Jim Figge – NY State DoH – Medical Director
Is this an attestation?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In stage one, yes. Now, we have a problem. Stage two may not be, well, we can just say it's an attestation. Now, we've raised it to 80% and now we have a denominator problem.

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, I was going to come back to the 80%. So, there is an issue with the 80%, that it's going from menu, where some people are not doing it at all, to core and then to go up to the 80 and maybe we should just keep it at the 50, and that seems to be pretty close to consensus. And just thinking about practice, that field.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. And where do we get the definition, denominator?

Judy Murphy – Aurora Health Care – Vice President of Applications
Good point.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We can't leave it as attestation?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We could, but how are they going to even know.

Judy Murphy – Aurora Health Care – Vice President of Applications
Even attestation has measurement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Karen.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Yes, that's the point I've been trying to make. Even attestation, if you put in a threshold it has to be auditable and where possible that denominator and that numerator has to be obtainable from the EHR rather than from paper records.

Jim Figge – NY State DoH – Medical Director
Well, it's a different kind of element, like maybe introduce HIE, you know, indicate that in a certain percentage of the time they have to use HIE to do this, a slightly different focus.

M
The other we could do is we could specify a minimum set of things that we consider relevant, so transitions from hospital to office, specialty consultations where patients have been prescribed new medication by a specialist. We could specify a minimum set. If people want to consider other things relevant and do med reconciliations then, too, that's fine. But we could just specify some transitions where we're calling out that it's required in the denominator.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, we're not trying to paint the world. People are going to be driven for other reasons to have MEDREC happen and they already are. Maybe we need to be guided by what we can measure. So, we do know the first visit with the new provider. That's in the denominator. Well, that's on the hospital side. So, on the EP side every time you have a new patient in your CPT code you're expected for 50% or even 80% of these times to have done MEDREC. So, how does that feel to people?

M
That's one. That would be one criteria. So, I would say hospital discharge is a second that would be required.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How would you measure that one? How do you get that?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
From a systems perspective when you're admitted you can track that you do a med reconciliation. I'm really worried about these transitions of care within the hospital. I think it's going to be a lot harder because today you've got to compare one list to the next list and when you're in operation you don't do it that way as much.

Judy Murphy – Aurora Health Care – Vice President of Applications
And if you go from a med/surg to a med/surg, we're probably not going to require it versus ICU to med/surg and then how do you capture that in the denominator? I wasn't thinking of measurement when we were talking.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Now, the other one is on discharge then. I think we originally had thought we would do one at discharge, but I think in the final rule it's only on admit that we did it, so then we'd have to think through how to capture that on discharge. But, again, when you're discharged you do med rec, you can capture that number.

Jim Figge – NY State DoH – Medical Director
On discharge and back to the ambulatory setting is when a large volume of errors occur.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And that's where we're having trouble with measuring it, yes. Because typically the outpatient systems don't have the knowledge until HIE kicks in. Well, maybe this is a place to put some HIE in.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
You want to do the reconciliation when they go back to the practice, that's what you're trying to measure?

Deven McGraw – Center for Democracy & Technology – Director
So, in other words, Jim, you're talking about there to be a transition electronically with an outside provider.

Jim Figge – NY State DoH – Medical Director
One of the instances when HIE would be possibly required on hospital discharge.

M
We… bring an HIE here but we can't use it for measurement because it's the thing where we'd be measuring the test with the test. We need something reliable that we can just use easily. But it could be a use case as you said for HIE, I'd agree with that. I don't know, the reason we ended up with stage one was because this was what was measurable. We picked the ones we could measure and said people will probably do the rest, so is there anything else we can measure. Instead of going back, to go forward, in addition to the ones that were in stage one what else could we measure?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Do we have the information in terms of the adoption? I know I've seen a lot of people defer this one to be stage two, so this is a much harder one to implement.

Jim Figge – NY State DoH – Medical Director
The other part that came in is that the specialists are saying they shouldn't have to do a med rec when they're coming in. And you could challenge that.

M
But call it hospital discharge as a place to start.

Jim Figge – NY State DoH – Medical Director
That would be nice. It would catch an at risk transition, but we have no way of telling when the hospital discharges occur.

M
So his point of view, when does the hospital discharge occur?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right, we'll go back to George's thing, which is we pick on something that is measurable and perhaps what we had in mind was and make sure that that happens consistently. That's why we went from 50% to 80%.

M
Let's go back. The original intent was to make sure that med reconciliation the functionality was in the system, which we now have the functionality. Now we're trying to move to the next step, right, which is to say now we want people to use it, to use the functionality and we're letting the fact that we can't measure it interfere with us calling out the fact that we want people to do it. I think that's a mistake. I think we should be able to call it out and say we want people to do it and let them attest to it, if we just specify three points of transition where it's critical and let them attest to the fact that they're doing that. Because if you just limit it to what we can measure then we're not really being consistent with what our goals are. Our goals are to have people meaningfully use the technology and if we're saying the only way we can make a meaningful use of technology is if we have an electronic way of measuring it, I think that's too limiting.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We can say our intention of how they ought to use it, but for them to attest that they've done med rec on 80% of the hospital discharges when they don't even know half of the hospital discharges would be, they can't do that legally, attest to the fact that they've succeeded in reaching 80% of hospital discharges.

M
It's not on the hospital discharges. It's on visits made to the provider following a hospital discharge. If the patient ever comes back you can't do a med rec, so it's not that I need to know about every hospitalization. I need to be able to signal that this is a visit that's a post-discharge visit and show that there's a med reconciliation done at that visit.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, even if I use the sampling technique, how would I as the EP even randomly pull some charts to find out whether it happened or not?

M
I guess you could establish a visit, which is a post-hospital discharge visit type in the system. I mean, if we have to do this, that's what I would do and I'd have a post-ER visit type. So if somebody came in and it was their post-ER visit we knew we would have to capture that information, you would have to capture it as a different visit type so you could pull those and make sure that they met certain criteria. I mean we don't do that now, but I think there's a way of doing that because it's not really every hospital discharge that we're counting. It's the visits that follow them and maybe we just do one of them. Maybe we just do hospital discharge, you know, post-hospital discharge visits.

Jim Figge – NY State DoH – Medical Director
We just say like within 30 days of a hospitalization.

M
No, it's whenever the patient comes back after a hospitalization.

Jim Figge – NY State DoH – Medical Director
Well, within the first 30 days or any time that they come back.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, this is going to be hard. So, maybe we deal with new to a provider and start there, raise the threshold to 80, which seems reasonable for that, right, Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications
Well, again, it's a menu set today, so if we make it core. It just feels like we should just keep it at 50.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And you're right, most people probably didn't choose.

Judy Murphy – Aurora Health Care – Vice President of Applications
I can guarantee you that.

M
So, this is going to be fresh for lots of people.

Judy Murphy – Aurora Health Care – Vice President of Applications
This is going to be an easier change like no other, I mean seriously, this is tough for providers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right, so the latest proposal on the table is keep it at 50%, move it to core and use the denominator of new to provider.

Judy Murphy – Aurora Health Care – Vice President of Applications
It's actually described okay, I think in the original one, which was, "When the patient is transitioned into the care of the EP or admitted to the inpatient or ED." I think that works.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Judy Murphy – Aurora Health Care – Vice President of Applications
But the intent, again, to say that it's other transitions of care and paying particular attention to the post-hospitalization next visit should be called out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, does that feel right? Okay. So, move this to core at the same level. Okay, so we are closing in on time. Let's see, how much more do we have for care coordination?

Christine Bechtel – National Partnership for Women & Families – VP
Summary of care record and then the two new ones.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Oh.

Christine Bechtel – National Partnership for Women & Families – VP
I know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We sort of did summary of care, right? So maybe we need to finish that discussion, because we already have part of a discussion and we'll have to ... care plan. Okay. Let's finish the summary of care and then let's do a check point and see where we are and see if we've gotten a lot of agreement on certain things. Part of it is this whole timing and then if we're in agreement then we can go finish whatever else we can finish today and then move the rest ... okay, what?

M
I have to leave at 4:00.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Yes. So we may not get to public health—well, we probably almost surely won't get to public health. Okay. Summary of care record.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. Summary of care record: Simply put, the last time that this group weighed in, not accounting for the HIE recommendation, the sub-group recommendation, it was to take the existing one, which is EP only and a menu set item and move it to core, assuming leaving it as EP to EP. However, the recommendation again, in the letter from the HIE Workgroup, was to change that to 50% of transitions and then the 30%. So I know we don't want to reopen that whole discussion, but I mean part of me says now we don't need this criteria because we've got the other one and so, again—

W
Yes, but the other criteria, again, I think part of Christine and I's problem about the other criteria is where is the beef—

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

W
It's just about the connection. It's not about what's actually moving. This is about what's actually moving, if in fact, we were to make it about what moves electronically. So this is another one that's a candidate for targeting for exchange versus having a process measure that's about connecting to at least one person. That's my only point.

W

So you're suggesting then taking this and actually elaborating also on what is in that summary of care record?

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I mean that's what people ask. I know a lot less about that, but just in terms of I think I'm still struggling with getting at the issue of exchange by specifying what it is that we want to move versus a mere process measure of whether you've connected to somebody or not. So there were a lot of recommendations through the public comment and there was consensus on quite a number of the items for the things that should be included in the summary of care records, because again, we didn't have clear definition at stage one. So you can see in the middle of page 64 the things that there was consensus on and then some things that were less consensus.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The middle of 63, right?

Christine Bechtel – National Partnership for Women & Families – VP
No, it's 64 on mine. Diagnosis, prognosis ... yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's 63, Christine.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. It might just be the way mine printed out.

M
Okay. How do people feel about this, the consensus items? Presumably that's if applicable, so newborn screening data is not applicable, for example—

W
Well, I think this may be another one of the areas where we need the Standards Committee to help us—

W
Yes.

W
Because we should be looking across all of – we have a number of summary type of things, so we ought to have some consistency, but recognize the contextual nature of each purpose, which is patient access versus provider use and care trends ... we're trying to make care transitions safer and prevent rehospitalization, so do we have what we need here?

Christine Bechtel – National Partnership for Women & Families – VP
The one thing I personally see missing, based on our discussion, Neil's comment about the reason for the referral or the reason for the data exchange, if you will. Why am I sending the summary of care record to you? What am I expecting you to do as a result of it isn't on here, so maybe that would be one we'd add.

Neil Calman – Institute for Family Health – President & Cofounder
I think there is no standard for that now. We need a development of a standard for how that gets transmitted as part of the clinical summary. I know that ... have that, but I think we should figure out if that's the standard or if there are other standards that should be adopted for that.

W
But, Neil, do you need structured data—

Neil Calman – Institute for Family Health – President & Cofounder
No.

W
Or do you just need—

Neil Calman – Institute for Family Health – President & Cofounder
No. You just need a place to—

W
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
Put it.

W
Right. Right.

Neil Calman – Institute for Family Health – President & Cofounder
So it becomes a standard part of the record.

W
Yes. Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So looking more closely at what's on this list, let me ask, ONC staff, when you said, "Consensus of items to be included," that is that somebody said something and nobody objected? Because this looks like a bit of a potpourri and many won't apply to each individual. Newborn screening is one example. Behavioral and psychological issues is another, so what made it a "consensus"?

M
It was that; somebody suggested it and—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And nobody objected?

M
And nobody countered to that ... yes. But those were not single points that came up. They were points that did come up maybe more than once.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So I think we can go back to—we need to go back to the Standards Group to come up with a summary of care record, our intent—and we'll qualify our intent. That's when we have our discussion with standards is to have some minimum kinds of information that goes along with the record and we weren't looking for the world, to cover all of these things.

W
And I think, Paul, we can use—I mean we did do some good thinking around this when we looked at the hospital visit summary, for example, that I think we should use here, because it's not just a standards issue. It's also a clinical—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly. And I think we even had a parentheses or the third column—I'd have to quickly look—

W
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, on summary of care didn't we call the third column comments? So we have a starting point. We can ask the Standards Committee whether there are standards around this set of data elements that we listed. Okay. So I'm going to attempt to come back and reconcile what Christine and Deven want in HIE, at my peril, of course.

Deven McGraw – Center for Democracy & Technology – Director
At your peril. There you go.

Christine Bechtel – National Partnership for Women & Families – VP
... let it go.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So here is a proposal: We just agreed on the summary of care record and the purpose really is to have this information go with everybody whether they see EHR providers or not. Okay? That's point one. Second: To test HIE—not to test—to require HIE we could say that a summary of care record; that you use certified EHR technology to transmit the summary of care record to at least one—

W
... at least one—

(Overlapping voices)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... at least 10% of clinical transfers.

W
Yes.

M
That's exactly what we have been saying. Yes.

W
In that case, if it's only one provider it still counts—

W
Right.

W
But it doesn't say connected to one person. So I was sort of thinking about how people have regularized referral patterns. If I'm a primary care doc and all of my cardiology patients essentially go to this one person, who really treats them very well, then the fact that it's one is not what's relevant. It's that the summary is being transmitted effectively for a certain threshold of patients in an electronic way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... all right. So now let's go to rural South Dakota and they're going to have ten specialists they have to deal with, each of which they use low numbers and you essentially force this one solo practitioner to convince ten of their specialists to commit.

M
Ten percent.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Ten percent of—

M

Not of the people. In 10% of the transfers of care. So you could have 10% of the transfers of care with one provider or two providers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So if most of the things get referred to a cardiologist then I've just got to make sure that that cardiologist—

M
And basically it's to get the flow going basically. That's what I'm hearing you both saying.

Christine Bechtel – National Partnership for Women & Families – VP
Right and if the cardiologist is also a meaningful user it should be a slam dunk. If they aren't you hope you can convince them, I suppose or we have to look at exceptions.

M
...

Christine Bechtel – National Partnership for Women & Families – VP
Well, it might be an—

Deven McGraw – Center for Democracy & Technology – Director Right. I mean we might think about opt-outs or impossibilities that we don't think can be done.

M
Yes. I agree.

Deven McGraw – Center for Democracy & Technology – Director
I'm certainly willing to entertain that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we should do that.

Deven McGraw – Center for Democracy & Technology – Director
But I think otherwise that where you're going is exactly what I was trying to articulate, which is it's not about the process of connection. It's about the sending of the document electronically and getting people to do that electronically. I mean maybe this will provide incentives for referrals to people that you know can take your stuff electronically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think just the opposite. It's going to provide incentives for specialists to get quickly configured to be able to do this, because they'll become the preferred specialist for primary care people tried to meet meaningful use.

Christine Bechtel – National Partnership for Women & Families – VP
Right. Paul, that's ... formulation. I mean the point is about—

(Overlapping voices)

Christine Bechtel – National Partnership for Women & Families – VP
... information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

M

So, Paul, I like the idea about linking these two. What would be even neater is we could link the third, this med rec. How do we? Is there any way for us to figure out that there was a transition and someone received this summary document and then based on that that's when we say we apply the percentage for med rec conciliation? I know that's what Jim was saying before. We're kind of going around in a circle about it. We're all struggling with how to do this HIE without having HIE functional.

M
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... don't want to get in the trap of if HIE is not functioning in the many communities in America where it isn't, that we don't want to exclude them from the program. That's where I'm concerned. We put a low bar to get it started. At least somebody could at least get an Internet connection and do NHIN Direct to get it started.

W
Right ... NHIN Direct require an EHR or is it a separate piece that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It requires an EHR and an Internet connection.

W
Okay. All right. So it's not a separate piece you can log onto, like HealthVault?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

W
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I'll move this back to our thinking group, our small thinking group, to figure out how to come up with another proposal to bring forward by the 11th, let's say.

(Overlapping voices)

M
... clinical ... of what the content should be? Because I think this list is incomplete.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. Yes. We're going to take our original list, which was pretty good—

M
... key things ... family history ...

W
Paul ... again – I'm feeling with our intent and some of the things that we're going to be elaborating on with stage two that it might be important to have a conversation now or later about is their intention at stage three to "mandate" HIE. In other words, will NHIN Direct still be acceptable or are we saying because it would be important to tell people that's where we're going so as they create their work plans they can think about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's a given intent almost in the legislation that by stage three people are exchanging information. I think it's early for us to know the maturity of HIE by that time. It's actually required in the HITECH Act. It's one of the required components.

W
Yes, except it's the different distinction between HIE as a verb and HIE as a noun.

W
Correct.

W
The verb is required. The noun is not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

W
And the Policy Committee, at least to date, has been very reluctant to tell people that they have to, by national policy, exchange through their HIE. Now—

M
No, but you have to exchange data to improve care coordination. That's what's in the law.

W
Yes. You have to HIE verb; it doesn't mean you have to HIE noun. Yes.

M
Or you could do NHIN Direct. We've already said you could do either one.

W
That's right, but your question, Judy, I took to mean are people going to have use the noun.

Judy Murphy – Aurora Health Care – Vice President of Applications
Absolutely; that's what I'm saying. With all of the money going into the states and the standards and interoperability framework, the big one, the national one, isn't that our intent? But again, that's a longer conversation clearly.

W
Yes. I mean one woman's opinion, but I don't think so. I think they will be viable options for people to use, but at least at the federal level. I mean certainly, well, Policy Committee wise there was no—people didn't want to go there.

Judy Murphy – Aurora Health Care – Vice President of Applications
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let me, before we wrap up I want to ask you – Paul Egerman sent us some draft information about where they're headed with the PCAST Workgroup and do you think that's a short conversation or a long conversation? Let me mention the two things: One is that there be provision for EHRs for patients to download information from there, let's say, patient portal and then do whatever they want to. Which could mean sending it up to somebody else or that a provider, at the patient's request, with the "address" that the patient sends the provider, send it directly to this other place, this patient representative. One way to look at it is if you use CCD, which is structured and has tags, so in fact I believe it satisfies the metatag requirement; that that download or exchange using CCD would qualify with what PCAST is asking us to do for a meaningful use criteria. Did you track that?

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And did I say it correct, accurately?

W
I think you did, although I think they were in part leveraging where the meaningful use group—they were skating to where you guys had already put the puck because we were talking about—we had already put the portal and PHR usage on the table. That sort of looked at that. I don't serve on the workgroup, but my boss does and that sort of looked like a way potentially in stage two to be able to get some of the data movement with ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think we've actually already satisfied that, if I'm hearing you correctly—

W
I think so.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we have too, because we actually use the word portal. We use .... Now, there is a nuance, which isn't such a big nuance. We had recommended picking CCD or CCR. The Standards Committee gave the choice. That becomes another one of these or things and I think it takes away from the structure, so we could readdress it unless everybody already agrees. I almost think we ought to do CCD because it has more structure and more tagging and I think—

W
CCD for the portal or for—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. Well, for everything, because it has better structure going from one place to another. That would be better for us even in our thinking and more consistent with the PCAST recommendations. So let me see if—

W
Well, I don't think PCAST—I feel like we're wading into the holy war again and it was so nice not to have to choose between two children. I can't recall that I was on the call where we made the choice of CCD versus CCR, because I sort of see this as a difference between the sort of more 2.0, lighter weight app based, platform based infrastructure and the EHR systems that have customarily used the CCD. If we tell the portal, say the patients can only get a CCD through the portal, I'd want to know a little bit more about what that means for patients exporting data and making it useful to them through applications, etc. I guess I'm not persuaded that we have to make the choice at this point and I want to know more about what the ramifications of that choice would be before I'd make it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So it turns out that the argument towards more structure actually helps the apps people to make more use out of this?

W
I agree, but certainly, the folks who run platforms that apps run off of were the ones telling me that CCR worked better for them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we can come back. So I want to propose that we come back and suggest, recommend to the Standards Committee that they pick one. Do you think that would do it? We're not the adjudicators of this, but express our intent of in order to make it more useful to all of the consumers, the systems that

consume data, EHRs, PHRs, through the HIE that they need to pick one with enough meaningful structure to make it useful.

W
I don't know. I think I'd much rather prefer to know why they chose not to pick one.

W
Yes.

W
When lots of people are pressuring them to do so.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that wasn't an easy thing to decide. How are we are the recommendations PCAST was asking for us for meaningful use? I think we've satisfied. Is everybody in agreement with that? Okay. Were you going to say something, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. I just wanted to backtrack for a moment on the conversation around summary records and the use of building that into the HIE criteria. I support, I think, the way Deven's going; that it should be part of that use case, because I think that was always our original intention of HIE. As you're kind of going in your subgroup, because the patient summary or—we've got a lot of names for these now—but the EP summary that goes to the patient is a physician-to-patient element. Should that then go back up to the patient engagement section and we look at that in that context as opposed to having an overlapping criteria up there, because I think it's provide clinical access or provide a summary and they then become the same thing. So the original intent, I think, was to exchange CCD or CCR, provider-to-provider through that HIE type of capability and then the summary was added as a later state in the process. To me, that particular objective feels like it should go be converged with the patient engagement section, provider-to-patient communication.

W
The summary of care record?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

(Overlapping voices)

M
Are there are clinical summaries in the patient engagement section now?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
No, I thought it was in the—

M
The care coordination has the summary of care record.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The summary of care record.

M
That's doctor-to-doctor—

W
Doctor-to-doctor.

M
Provider-to-provider.

W
Yes.

M
The clinical summary is in the patient engagement section. That's provider-to-the-patient.

W
The visit summary is provider-to-patient and that's—

M
Already in there.

W
EP is the summary. Hospital visit summary is hospital. Both are inpatient.

W
When I listened to you talk about it Paul said every patient going out the door gets a copy of the objectives that we were just talking about, so—

M
I think ... to say that.

W
It just seemed to overlap.

M
... fixed it, but it's inpatient engagement—

W
I mean they do overlap because they're ... same data ...

W
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Let me try to summarize and then talk a little bit about timing. Josh, I wonder if you could help us with the objectives that we moved further, how many small groups we need to form? Can you list off those things?

Josh Seidman – ONC
Why don't you come back to that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Well, the other ones also involved you. It's the number of new functionality that's going to require new certification and then the menu items, which also are certain, so that's included, the new menu items. Well, I'm trying to figure out from a timing do we have to raise how do we deal with the timing issue? Do we have a lot of things? I'm trying to get to a time discussion, so we can give Josh a couple of minutes to assemble that.

So where I'm headed is remember the four timing options we talked about. One is keep everything the same, meaning stage two begins 2013 or the last quarter of 2012 for hospitals. Another option is the opposite, which is you delay stage two for a whole year, the whole thing. A third option, which we can act on also separately, is the 90 days versus 12 months reporting. And the fourth option is this hybrid where

you continue the ones where no certification is needed, which means no new development is needed, which is mostly the increase the threshold, and postpone the new functionality.

W
...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I put it in an e-mail ... that the FYI here was the – I can go through this again. So, one, we keep it the same. stage two starts on schedule, 2013 or 2012. Two: We push the entire thing one year, so stage two would start in 2014 or the final quarter of 2013. Three: A separate topic, which is change the reporting period for stage two from one year to 90 days, like it was in stage one. Four: This hybrid approach of keeping the same timeline for things that do not require new development and new certification and postponing the new functionality some X amount of months. So let me see what people's sentiments are to the reporting period, because that seems a completely separate kind of decision; 90 days versus one year.

W
Well, I guess I have two things. One is I don't know why it would have to be 90 days. Why couldn't it be six months?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It can be whatever we want. We're just used to 90 days. Ninety days gets you nine months. Six months gets you six months. The reason it was 90 days; they did that in stage one. People understand that and it buys you nine months of time.

W
So I think where I'm going to struggle a little bit is to know the impact of the decisions that we made today on the overall list of where new—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what Josh is working on or somebody is working on.

W
Paul, I don't think we need—to add a little more complication—these don't have to be mutually exclusive. Like if the rule comes out in April or sooner then you gain some time and they have six months to get ready. Then if you do 90 days you gain nine more months to get ready. There is a possibility of rather than moving it a year you move it six months, so there are some combinations of what you suggested that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes—

W
And I think CMS in the final rule they did use a lot of different strategies to give as much lead time as they possibly could in stage one as that rule was written, but I think also in the rule they also kind of clamp down, like you can't skip the flexibility for stage two. So we need more flexibility in achieving stage two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think if I heard you right what your first point is is there are permutations of what I said and that's totally fine.

W
...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's probably very optimistic to think that the timeline of mid-2012 is going to be moved. I don't think that that's unless, Karen, you want to tell me different; I've never heard anything different from that. So—

M
...

W
We had heard ... who knew where we heard that ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So are people comfortable making a recommendation about the 3 months, 6 months or 12 months?

M
I recommend 90 days.

W
I'll second that motion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Any further discussion?

W
Well, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

W
So let me make sure I'm understanding: So this would mean that the reporting period is 90 days, so all of those thresholds that we have struggled with would be very difficult to meet, wouldn't they?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, because you need it within—

(Overlapping voices)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You need it within the threshold. You get to meet, implement—

W
There's a smaller number of patients—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

W
You only have to be a meaningful user for 90 days in the second go-round?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

M
The same way it was in stage one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
Just if we do one of the other options and we could do both ...

M
We could.

M
We may not need it if we—

M
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This has the least amount of administrative overhead to gain the most amount. There is no change in the deadline.

W
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It basically gives us the most flexibility in time at the lowest cost in functionality and objective criteria.

W
I certainly support being more flexible on the timeline. I think 12 months as a continuous period is tough, but I guess for me 90 days feels like a little bit on the other end of the spectrum and I think it would be a little more comfortable with something in between, like around 6 months would be better so that we see that there is something. I mean a lot of what we're asking is a very significant change and my guess is that what will happen is that it becomes more attractive to do the fewest things possible to meet it in the reporting period. So I would rather see a longer reporting period that will give us a little more of a sense of people doing things consistently and well over time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any other discussion?

W
Again, on the 90 days, again, it's a factor of when we get that final rule. If that is July then we have to go through the certification process with the finished development. We've got to go through the certification process, deliver that to not one, but many customers at that point, because we're going to have a bunch, not just a few customers, hopefully a lot of customers up on stage one. That takes a while, so I'm not even sure the 90 days is going to help us get the customers to where they need to be to get to stage two on time, because in stage one, again, just a few people are running, but when you get to stage two a lot of people will be running stage one and they all need the software to get to stage two in the time frame, so it changes the rollout process where rather than just a few it's a rollout to many, which is a pretty complicated process.

W
I just am wondering, Karen, I hate to put you on the spot, but mid-2012 is more than a year from now before we'd have a final rule. Is there anything that we could do to be helpful to accelerate that? I mean I guess that having the balance between understanding what's happening in the field and how it's playing out, but given the fact that a lot of what we're doing is not significant changes, is there anything that we could do to move that time frame up so that the rule was out much earlier than mid-2012?

W
I think we always try to get things out as quickly as possible, but there are things like department review and OMB review that are outside our ability to control and we will also be operating in a much busier

environment now, because we're rolling out a lot of the Affordable Care Act regulations. So we're making some assumptions of what we feel comfortable to deliver on and we always try to get them out there.

M
And don't forget ICD-10 implementation is coming 2013, so people are going to be very busy with things.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So I didn't hear, Charlene, you objecting to getting nine months. You're just saying that you're telegraphing that you think it's going to take more than that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
... I mean unless we raise thresholds, if we come to—

M
...

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, if we have a strategy in stage two, let's leverage all of the software we've delivered today—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And raise thresholds then that's a different scenario than adding net new function and big chunks of stuff.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Are we ready? Any more discussion on—

W
I mean is it possible to do an analysis based on our discussion today about what would we lose if we were doing that kind of approach? I mean I think some kind of a balance between the two might be good. I'm just feeling a little hesitant of maintaining a big recommendation today on that without stepping back and finishing. I mean we haven't finished going through what we want to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, it's only going to get worse. Marty?

Marty Fattig – Nemaha County Hospital – CEO
I would really like to see some data before this decision is made regarding how our providers and hospitals are doing at meeting meaningful use stage one. Is that happening at the rate we would expect or is that below or above? Is it, "Oh, yes, this is not such a big deal and maybe we can jump," or is it, "Oh, no, everybody is struggling. We need to slow down."? So I would find that helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think we would find it helpful. I'm not optimistic that we're going to get a lot of data, because even the people who even intend to quality by the end of 2011, which is maybe not the majority, are just not going—we won't know by May or June, so I don't know we're going to get a whole lot of information on it.

W
But I mean we do know and we would know from people like AAFP and the RECs what their strategies are for getting people up and running, right? I mean they'll tell you and I wish that I could bring it down, but I didn't. They'll say, "Look, you need to focus on four things and four things only and if you hit those four things you're going to hit almost everything else in meaningful use." I mean that's what I'm hearing them talking about. I know we did get a report from that implementation hearing, which I didn't have the chance to go through.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I read it. I'm not sure. There's a lot of caution in there. So can we get a sense? The reason I'm asking for this is for next week. We actually have to talk about it to the committee and get some feedback from them, so it would be helpful for me to have a sense of this group, where we feel on some of these issues. So I thought the easiest one to deal with was the reporting period, so the motion on the floor I think that was seconded is 90 days, 3 months, 90 days. Can we have a vote on that, whether that's something we would, as a straw person, feel good about?

M
It's a possibility, depending on what else we do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So what's your vote, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So, except for Deven and Christine, the sense of the group was yes? Okay. Do have some information about ... what we've done so far in terms of pushing things out?

Josh Seidman – ONC
... about the specific kinds of small groups that need to be discussed. Yes. So the first one is in CPOE the issue of basically working on the denominator definition around the new developing of a radiology interface because of whether it needs to be transmitted electronically and so there's a question about the denominator that would need to be discussed.

M
Whether it was measurable, do we have a reasonable ... who have had radiology ... people who ought to have radiology orders. That was the question. Do we accept it or do we ...? Because we weren't going to transmit radiology orders electronically. That wasn't on the table, right?

Josh Seidman – ONC
There was going to be follow-up on the drug-drug, drug-allergy related to the change related to employee and the definition of that. The third one was regarding; I think this is more probably looking towards stage three, but around smoking status and second-hand smoke and looking at what current systems can do now, but I think that that discussion was more focused on stage three.

There was; I didn't quite know where to put this one; something about creating a signal list. This was in the discussion of the family health history, but basically in family health history there was a lot of interest in incorporating that. I'm not quite sure exactly how because it was somewhat new and so there was some thought that that needed to be discussed and then also taken to the Standards Committee. The drug-formulary checks: There was discussion about why this is important. We need to come back to some language to explain that, to describe that.

On advanced directives the question of whether it was reviewed and that would potentially bring some future certification criteria and so that, again, I think was probably something that was maybe not necessarily a stage two question, but something to come back to. The structured lab data: Jim Daniel is going to work with a small group on some of these issues around the structured lab data and LOINC and so forth. For patient specific education resources, sort of coming back to the question about whether the HL-7 info button standard should be used: That was sort of a discussion that we need to take place with the Standards Committee. On patient preferences for communication there needed to be some more granularity of the categories, so that work needs to be done Then there was, I think, the HIE bucket still: It's big and probably requires the further discussion with the IE Workgroup. Those are the top ten.

W

Can I add? The one that I think is missing is we did say we needed to talk more off-line about how to ensure there are some core items in the patient and family engagement area that give patients access to their health information from both the hospital side and the AB side to get particularly the hospital side going to a portal approach for discharge instructions would be menu and, therefore, there would be no core requirements for hospitals on information provision for families.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So let me see—I think there were a number of things that we passed ourselves to write in the preamble and hopefully you have those written down in the ...

Josh Seidman – ONC
... get into that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we need to beef up the preamble. Then let me call the stage three signals. We need—

Josh Seidman – ONC
There were a couple of other issues that were just sort of some questions for the Standards Committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Some of the things we wanted to signal, find a way to signal the vendor community in a strong way included the second-hand smoke; the structured family history; the advanced directive reviewed check-off, basically understanding how recent this was reviewed; and the hospital portal during the admission. So those are things we wanted to start working on and give them a signal to go in that direction.

The CPOE: These are more of the clarification, working out some of the precision and definition. Let me see if people can volunteer for this. I think the best way is for us to have somebody present a suggestion, a draft to the April 11th call. Otherwise it's just going to be we won't have enough time. One is the denominator for labs and radiology and CPOE. Does someone want to take that?

Judy, you're a specialist actually.

Judy Murphy – Aurora Health Care – Vice President of Applications
...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. That would be great. Drug-drug interaction, the whole high-low kind of thing, how to sort of word that so we get substitute for the evidence-based phrase ... has to work on that one ...

M
I'm still trying to figure out why April 11th isn't on my calendar.

W
Yes.

M
It's not ...

W
The next meeting I have is May 7th.

M
Yes.

M
...

M
Yes. We don't have anything for the 11th.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Uh-oh.

M
There's nothing on there.

W
...

M
I think it's, my time, 7:00 to—that's a problem then, huh?

M
Wait a minute. April 11th?

M
Yes. Do you have anything on the 11th?

M
No, I don't either.

M
No. I have MU call 9:00 to 11:00. I don't know if that's still active.

W
I don't have—

M
I don't have that.

M
I do too.

M
You have what?

M
6:00 to 9:00, which is actually your 9:00 to 12:00.

M
Oh, you're right.

M
9:00 to 11:00, but that's okay.

W
On the April 11th?

M

On April 11th.

W
No.

M
No. None of us have that except the chairs.

Judy Sparrow – Office of the National Coordinator – Executive Director
I'm sure it was sent out. I'll double check that in the morning.

M
Well, the chair and vice-chair have that, but nobody else does.

M
Well, that certainly narrows down the—

M
So now we know who's bringing the proposal.

W
Yes ... let us know.

W
Yes. Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's a problem. So can you guys meet during that time?

W
No.

W
No.

M
...

W
It's a week away. No.

W
Yes, I can't meet ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right. Okay. So that—

M
...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Or here is May 13th.

W
We've got our ... Policy Committee meeting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let me get through some of these to-dos and let's get somebody to work on each one. Drug-drug interaction, just the wording of the evidence base to make allowance for further information becoming available.

M
Jim is volunteering.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Jim and Neil. Okay. Smoking, no, that went in the second category. Structured lab; that's basically dealing with the LOINC, right?

M
...

W
... wasn't that covered in the IE Workgroup letter? I think it is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we incorporated that by saying we put it in the hospital, right?

W
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Patient specific resources. What was the question there?

Josh Seidman – ONC
... related to the HL-7 info button standard, whether there should be a standard incorporated into that. We could just bring that to the Standards Committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Standards. Okay. Patient preference categories for how you want to receive information. I'm not sure that we need standards for that. I think the fact that you can record this and let people do what's locally relevant seems to me that – does anybody object—

Josh Seidman – ONC
The question was around the granularity of the categories—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Josh Seidman – ONC
Not around the methods of transmission, but around parsing out different types of data.

M
Right ... versus—

M
I don't know why that should be a national standard only in that it might kind of ... privacy kinds of things that certain kinds of information might be considered more sensitive than others. I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do Deven or Christine have a preference on—

M

Is that ... the word privacy ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't know.

Deven McGraw – Center for Democracy & Technology – Director
I'm not sure I completely understand the assignment, but I'm happy to take it.

M
Well, no. No. It doesn't have to be. I'm trying to argue whether it's an assignment—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
An assignment at all –

M
Because I think it's this is how you record it, communicate according to patient preference and one of the questions is do we standardize either the modes or—

W
I don't think we do.

M
I don't think—

(Overlapping voices)

W
I don't think that's a standard—

M
I don't even think it should be standardized.

W
I don't think it should be—

M
Well, do you think that the preference should—

W
...

M
We need a field for it, but to standardize how many fields?

M
Well, do we think that the preference should be inherited from one in the transition of care? Does that need to be established at each site or can a patient decide and then it's inherited where the next bit of information flows to that this is my preference?

W
Oh, it would be inherited if someone actually shared it.

M
That's' why it could be a national decision is what Paul is asking. Do we want to share that? If we do then we need to make a decision about how to standardize that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But I think if you transfer your care that you may have a very different opinion of where you want it, so I guess what I'm suggesting is it's not a standards activity. Okay? So we wanted to make the placeholder in the systems, but not a standard, so cross it off the list. Who wants to work on the HIE clinical data, the mixture of what to transmit in HIE, the proposal to come back to us?

W
That's also something that I think the IE Workgroup is working on, so I would definitely be okay with serving that transitional role.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. That would be great. So whenever we're on a call next you can ...

W
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Then what we are committed to present next week at the HIT Policy Committee is some thinking about timing so that we can expose that and have the group react, the whole committee react. So we had a sense of the workgroup about the 90 days. Now let's talk about the harder ones. Considering the trend, the trajectory we have and what we're saying about the objectives we have so far, that's where I could use some help in what are the things that seem to require more development and menu? What are the new things?

Josh Seidman – ONC
There seem to be a couple. Some may depend also on the discussion that you have in the smaller workgroups, but the first one was e-prescribing for the inpatient setting. That's not addressed currently. Group reporting with TQMs. That's a possibility to have in the standards. That may change depending on revisions. The recording of the family history: The question was are there any standards that currently exist. There just needs to be some exploration there. Recording of advanced directives: You discussed just including a checkbox.

Incorporating the lab data: Right now the standards talk about LOINC, but again, this is something to explore or to add or to make sure it's the right language that is necessary for what you are hoping to achieve. The EP note is searchable, scanned. We need to find out if there's a standard for scanning and searching. Same with any of the new objectives, so again, electronic notes for EPs and for hospitals. Medication orders automatically chart to the EMR.

Info button standard for patient specific educational resources: That's not included currently. Another new standard is the ability to view and download, so everything, all of the new ones that pertain to a patient portal or access. I think we stopped—oh, on-line, secure, patient messaging and then patient preference for communication. I think we stopped at that point. Is that right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene, if you were to look at this list and say which ones are the hard ones to develop and implement or the ones that stand out, so let me give you a counter example: Progress note and the electronic documentation and this med, the EMR are things that are pretty much already there, so that's an example of something that's not requiring ... correct?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The one that would be just kind of the no-brainer would be if you did progress notes for ambulatory, because it's pretty much there. In the hospital it's harder. That's newer development, so that's kind of it's emerging, so that would raise the bar. In the EMR I think in the in-patient setting it's there and again, how extensive that goes. I don't know about the info button. I mean we've got the patient resources there already, so I mean anything adding to it would add some development.

M
I don't actually know that we talked about the info button per se.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't know either, so—

M
... connecting the data elements in the EHR to content to health information to content—

M
...

M
That's what the ...

M
The info button standard is in HL-7.

M
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Standardizing family history would be a big one, I would think, just because I'm sure it's all over the place today. The group reporting is a big one because, again, today measures are written to the individual provider and aggregate. They usually don't know how to do that and what that means. E-prescribing for inpatient: I don't know. I mean just from ... perspective it's a bit on the roadmap. We could get it there. It has to be certified, so that doesn't jump out at me, but I'd have to check with other vendors. The advanced directive I think is pretty much in place. That doesn't seem to be a big stretch, except I would wonder, again, on the EP side what the impact would be on the hospital side kind of ... practice today.

Then the one that's missing that I think was the outlier that impacted us this time is the impact that the quality measures brings to the table. That's where a lot of work went to this time, because once those measures are defined we have to back track through our system and look at what data has to be captured, map that data to the elements and then create those reports. That's a really big investment. So if what we did in stage two was keep the same measures, start to report them to CMS, because we're supposed to, and yet use that same data set we might have to update them because the standards are out of date right now. That's a doable thing, but if there are a bunch of new measure that are coming in there will be a lot of work surrounding that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What about the patient portal and secure patient message and those sorts of things?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think the secure patient message was okay. I think pretty much the consensus was that there wasn't a lot of red flags. Again, I think on the hospital side there'd be work to be able to do that, the hospital side of the patient reporting. There's been a lot of work on the EP side for the messaging, so I don't know what that silver bullet is intuitively from the hospital side, so I would think that would raise the bar. We've got discharge instructions. We've got patient instructions, but that access chunk is the challenge. Health information exchange: Again, I think most systems are well positioned to do that today, so that's something we can build on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So listening to where we've headed so far, what are people's sentiments on the split of ... functionality and raising the bar versus new functionality? Do we think we need that kind of hybrid?

Christine Bechtel – National Partnership for Women & Families – VP

I mean I certainly do. I mean as I counted up the chart the chart was almost evenly split between new things needed and not, but then as I'm listening to Charlene, a lot of the new things it sounds like; definitely not all of them; but a number of them are part of existing EHRs, like advanced charts, etc., so yes there is new and yes there will be adjustments, but it's not wholesale coding of new stuff. I think there's actually not that much brand new, never done this before kind of a thing in here that would cause us to step back and say, "No. No. No. We shouldn't really advance things," because we really advance a different – just sort of raising the bar in stage one to me continues what stage one was about, which was electronic data capture. So to get to information exchange and ultimately outcomes, I feel like we do need to advance another, an additional set of criteria and I think we're okay to do that for the most part so far. I don't feel like the industry has said to us, "We're going to die. You can't do this," at least not yet. So I think it's a good, hybrid approach.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. The hybrid was raise the bar on time and postpone, but not—

Christine Bechtel – National Partnership for Women & Families – VP
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No?

Christine Bechtel – National Partnership for Women & Families – VP
I'm sorry. What? Raise it on time—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So one option is keep it the same. One option is don't move, do a thing for another, let's say, year. The hybrid is raise thresholds on the current timeline, which is 2013, and delay the new functionality by, I'll just put out there, a year. That's the hybrid.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So I'll just clarify: I'm saying keep it the same, because in my mind it's a hybrid between new objectives and existing. But yes, I think there's a good rationale for keeping it the same.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay ...

M
When you say delay are you talking about the nine months we're getting? That's a different delay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a separate delay.

M
Okay.

M
... well, or ... if we do this we might not do that. We can decide.

M
Oh, I've got you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If they're that equivalent then I would just do the easy thing, which is just to ... so if we need more than nine months then we need to find other mechanisms, yes. Other comments?

M

... stage two A and B, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. That's correct.

M
2A would go in with current extent functionality and 2B would be ... for your delay for the new functionality—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

M
... developers time and so on and get the products distributed. I would favor that approach.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Other folks' comments?

W
Would you make then stage two be the all core?

M
All four?

W
All core. Do you still have a menu and a core?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the development time is development time regardless of whether it's core or menu. They still have to develop it.

W
I agree and so what I would argue is that from a vendor perspective if everything is core then that's fine. What it really gets you is it gets you the provider side of having to implement a set of core functionalities, a different set of functionalities in the second year of the second stage.

M
Right.

W
... to ... suggesting ... maybe 2A phase at a full year measurement or—

M
No, it's independent.

W
They are completely independent?

M
Yes.

W
Okay.

W
They have to be.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you have—?

W
... 2B—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Like the 2A/2B?

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Deven, do you have—

Deven McGraw – Center for Democracy & Technology – Director
I'm sorry. I was distracted.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I'm good with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're good with that. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... ask me?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Of the four options keep it the same, delay everything one year, split it to 2A and 2B; 2A is all existing certified functionality, but raise the threshold and B, which is delay it, I'll just put on the table, a year where it requires new functionality.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that's a good option if the other one is not good enough.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If the nine months is not good enough?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think it's a reasonable option, but I want to know that the other one doesn't work by itself and then it—

W
And then ...

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

If you delay it a year it's a year measurement period, but we're not going to go then nine months ... only required a three-month measurement period for those.

W
Couldn't we do ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're considering them independently right now.

W
It would be hard to do a year measurement period. I think my ... keep it the same. I'm interested in exploring the 2A/2B idea, but I would want to understand whether the menu and core approach stays or everything becomes core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fair. Remember that the vendors are in a different menu. They have to still do it—

W
I know that, but my concern—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... implementation ...

W
... the vendor technology in a lot more provider communities willingness to do this in a 2A/2B, so I mean you can't just think of one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think I would agree with George that if the nine months doesn't suffice then 2A/2B is probably the right way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Marty?

Marty Fattig – Nemaha County Hospital – CEO
I'm of the opinion that 2, as it currently stands, is very aggressive, so I like the 2A/2B and also the nine months.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Marty Fattig – Nemaha County Hospital – CEO
For the ... yes, 90 days. Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think the position actually the Policy Committee approved was an 18-month time window, so we're trying to manage to try and get that, I think, out of the scenario as best we can from the point of the final rule to when providers need to be up and running, because that's kind of the boundary that we're working on, so it seems like we're going to need a combination. I'm definitely on the 2A and 2B. My concern there, again, is we're adding complexity to the whole certification process and all of that kind of process and

somehow we're going to have to fix that, but definitely, giving as much runway as possible for the stage development and adoption of these systems. But again, raising the threshold of the software that's in place today seems to make a lot of sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So Deven?

Deven McGraw – Center for Democracy & Technology – Director
What I struggle with is it just feels really premature to make this decision, really premature. I get that we're being pushed, but we are like in month three of stage one and we're being already asked to delay. I feel like it's way too early.

I would definitely signal my willingness to consider any one of those options when we have more information about what is really going on in the field, because some of the adoption escalators you can move up really fast because once you do them for one set of patients it becomes that's the ramp, that's the hard part and then expanding into more becomes easier and it just depends on what kind of functionality you're talking about, how much workflow is disrupted by it and it's probably an individualized determination based on what you're asking people to do, so I obviously though sense that we need to do this sooner or later for the items that vendors need a significant amount of lead time to develop and so I'd much rather take a look at those and make some decisions about those than be universally deciding what we're going to delay in early April of 2011.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So it sounds like the majority though were in favor; their sentiment was the 2A/2B and that's how we could present to the HIT Policy Committee, as far as this is what the sentiment is. We have until June to come up with the final—

Deven McGraw – Center for Democracy & Technology – Director
Yes. I mean I prefer for that to be expressed as a sentiment with some dissention.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Deven McGraw – Center for Democracy & Technology – Director
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Absolutely. Maybe I did think that my ... before and it didn't work out, so I'm not going to ... okay. So what there remains to be done, how many calls then do we really have between now and—

Judy Sparrow – Office of the National Coordinator – Executive Director
I'm going to have to get back to you. I thought Altarum sent that out for the 11th, but I guess they didn't.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So we at least have May something, May 3rd or something.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, May 2nd.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
May 2nd. And we have our hearing, which is not used for this. Do we have another call?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. We have two in May and then the hearing.

W

...

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, May 2nd, May 10th, the hearing on May 13th and then June 1st.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But how many do we have before the May HIT Policy Committee? That's important.

M
May 2nd and May 10th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
May 2nd and May 10th and then our policy meeting is when? May 11th. So it seems like we need more time together to finish up the other two categories. One of them is hopefully pretty straightforward, either because we're not making changes here; we're relying on the Privacy Tiger Team, the GRR. We have population health to do. So we just have to make sure we have it all nailed by the HIT Policy Committee meeting in May.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
At this time we're going to talk about timing and maybe just some general sentiments. So in some sense the things we've talked about so far were fairly close to our original recommendations I'd say, with some tweaks, with some helpful tweaks. I'll go back and look at the changes. So that's what I think we'll present to the Policy Committee in April. Does that make sense, folks?

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Because that's about as far as we've gotten.

Deven McGraw – Center for Democracy & Technology – Director
I agree with that. I think I'm just really having heartburn over this timing thing. I mean I know that we threw out three options or whatever on the phone and then to have a ten-minute discussion about it, I mean this is a major decision and I don't understand why we're being pressed to present something to the Policy Committee in April.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're not presenting a decision. We don't even have a decision here. We have a sentiment that we'd like to get some more input on from the rest of the Policy Committee, so we wanted to first talk about it, talk right on the context of what came back from the RFC and based on what we've heard so far from the RFC and how we've discussed the first three categories we have a sense that we're asking for; I'm just reading from the majority; quite a bit from the community at large and that's a combination of the vendors and the providers, who have to implement and that if we want to maintain that momentum, the whole escalator thing, instead of giving up the whole ship, which is delay everything, which sends certain signals or causing people to not be able to make it and we lose there too. There may be a hybrid that causes us to continue momentum with stuff we already have installed in our systems and yet, give some development time and implementation from a provider perspective we're working out the implementation time to these things. Does that seem like a compromise to at least talk about?

Deven McGraw – Center for Democracy & Technology – Director
I mean I think it's okay to talk about, but what I'm really concerned ... is we don't even know if we've gotten it right in stage one and the fundamental presumption, I think, in the way you characterized it in our discussion is that we didn't and we don't and we're asking too much and it's all too hard.

M
That's a good point.

Deven McGraw – Center for Democracy & Technology – Director
Well, right. Because why else? If everybody hits stage one then an increase and a threshold shouldn't be that big of a deal and the real issue is the new functionality. What we really should be doing is taking a look at really specifically each new functionality that we're asking for and doing an in-depth analysis with Charlene's support and leadership where we say how much of this is really new. Everything would be a new certification process, but as Charlene explained, that doesn't mean it's necessarily new programming and new to the system and we don't know that right now except what Charlene had to rattle off the top of her head – and God bless you for doing that. I really appreciate that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
...

Deven McGraw – Center for Democracy & Technology – Director
But here we are going forward with what feels to me is a fundamental, underlying assumption that it's still too hard and it's too much. I just don't think we know that at this point yet. So I think certainly having that analysis would be helpful, but that's my concern in going forward. I think it's signaling the wrong thing out to the community. I mean you'll recall there was a huge hubbub over CPOE in stage one, huge. We didn't see that at all in the comments here, but I don't know what conclusion we can draw off of that. So to translate that to the larger discussion of timing, if everybody made such a humungous fuss about it, had we pulled it out of there completely, as everybody urged us to do, we would not be in the place that we are today where suddenly there might be some indication that it's not as hard as we thought and so starting at this point with a discussion about how do we relax the timing, how do we relax the threshold, how do we relax the criteria, it just feels really premature to me.

M
I might just mention from my vantage we have periodic calls with CMS and there was a specific call a couple of weeks ago with CMS about this very issue. They have very grave concerns about the fact that the pace is going too fast, that there's—

Deven McGraw – Center for Democracy & Technology – Director
The pace of what?

M
The pace of implementation for phase two is going too fast. The states have all had this discussion and there is fairly unanimous consensus among state Medicaid agencies, as well as CMS that there needs to be some mechanism to slow this down a little bit so that we can have time to do the development appropriately and do appropriate adoption, so I think this is a very deep seated and widespread concern.

Deven McGraw – Center for Democracy & Technology – Director
I'm not suggesting it's not deep seated or widespread but if, in fact, this is a universally held belief of the agency that ultimately these recommendations get reported to I would prefer that it come to us from a channel other than somebody's comment on the workgroup. No offense, Jim. I know you participate in a lot of these things, but we have some independence, but in fact, CMS wants us to slow down I'd like to get some official communiqué on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I was just going to say I think that for all of those menu items that were in Phase 1 we really have to get a much better feel for what people picked, because going back to Charlene's point, the implementation being the key here, if there are things that people really shied away from we need to know that in order to

act intelligently on those items. So I would think that we should present this to the Policy Committee more along the lines that Deven said, which is that we need more information. As that information rolls out that we're perfectly willing, as you said, to consider a variety of options, but that we're looking for input from CMS. We're looking for input from the RECs. We're looking to understand what kinds of selections people have made in terms of menu options that were in Phase 1 and that as that information rolls in we'll be able to make more intelligent decisions about recommending timelines.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think—

Neil Calman – Institute for Family Health – President & Cofounder
Is that a reasonable compromise for everybody?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me; and maybe this is what Karen's going to say; we have a timeline and then CMS has a timeline—

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we, unfortunately, I don't think we will actually have the information that we would like to have by the time we have to deliver our June recommendations. We just won't have that information even for the people who intend to apply in 2011. Now, CMS has another six months after receiving our recommendations and hearing from the field as it prepares its NPR. Then it has another six months to make the final rule. So the considerations of what really happen is going to be used. It's just that we, based on our timeline and having to start the process won't have; I'm fairly pessimistic; we'll not have that information that you seek ...

Neil Calman – Institute for Family Health – President & Cofounder
Then I think if there's a slowdown that's needed and it's based on information that's going to happen after our recommendations we should make a recommendation and let the slowdown come from the people who think that it needs to be made. I mean CMS always has that option.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Neil Calman – Institute for Family Health – President & Cofounder
But I think if we can't get that input in time for our recommendation then I agree. I thought that we would have some of that input, but obviously—

M
We just voted on—

M
I'm voting on viable options—

Neil Calman – Institute for Family Health – President & Cofounder
Right.

M
Period. I voted on that's an option, that's an option.

Neil Calman – Institute for Family Health – President & Cofounder
Right. Exactly.

M

...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And just to address it, so one of the ways we could present even our final recommendation in June very much along the line that some people are saying here is if you get pressed for time because it's aggressive when you find out and you get more information from the field, then here are some options that the workgroup, the committee has looked at and may seem viable for you to consider. That can be—

M
... might want to say rather than slowing down the whole process we could see segmenting this into different pieces—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. Correct.

W
And the pros and cons ... how they work together, because that's the thing—

M
Right.

W
We're already saying go back 90 days plus ... I mean they all work together.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Okay. So—

M
... just regarding Jim's comment, because there is a summary of that call with the states that Jessica Kahn from CMS sent. She specifically said that there was some concern over the timing; that they would recommend either changing to a 90-day reporting period or delaying a year, but not both. That was the sense of that group, so just to clarify that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So, Karen, did you have something to say?

Karen
I ... some of the discussions that are going on ... operational and I think many of the Medicaid discussions are more on an operational bend. There are also clear policy imperatives involved here and we've been working with ONC all along and plan to continue to do that to look at both, the broader policy implications and the operational implications.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I have to catch a plane, but George will take over in terms of having the public comments. Thank you, all, for being here, for contributing, for getting here through the weather and for the healthy discussion—

W
...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Pardon me?

W
... back ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And so we will talk to you, I guess, not on April 11th, but we'll talk to you in May. Thank you.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
... Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. If anybody in the room wishes to make a comment, please step up to the microphone. Please state your name and organization and there is a three-minute time limit.

Jim Hansen – Dossia Consortium – Vice President and Executive Director
Good afternoon. Jim Hansen. Dossia Consortium, a non-profit employer sponsored group. We represent five million employees, dependents and retirees. I have a couple of comments. If you go back to the HITECH Act one of the main goals was to engage patients and caregivers as part of the care team and so I think as we think through the portal and secure messaging I think that that's a very important component. I think that's the expectation of consumers. They've had on-line banking for ten years. They're used to that paradigm shift.

In terms of the capabilities ... ACOs in medical homes are going to require that kind of capability and so they're already going to have to do appointments, refills, lab results, those types of things. If you're going to be doing that, e-visits, then adding this capability falls into it. So our recommendation would be that if they have a portal that does those types of secure functions then they should be required to provide that capability to the patient. I also want to remind everyone that VA and HHS from conception to delivery did the Blue Button in six months with 100,000 vets downloading their records in 45 days. So the demand is there and they were able to do that and that's certainly not two years.

On the push side, as the conversation went, we very much support leveraging what's gone on with Direct. The system-to-system component, that process has been very successful and there are 60-some organizations lined up to support that, including Dossia. In our perspective, having Mary.Smith@Direct.MyHealthyVet.gov is an address that's in the preference part of EHRs so that whenever my encounter is over or I'm discharged, boom! It sends it off to either my secure e-mail or off to an HIE or off to a PHR vendor. It's efficient. Nobody has to do anything. It's system-to-system and it is effective. Again, if they're using Direct we ought to have them do that as well.

Dossia participates in the transitions of care over on the standards and implementation side. We're working on discharge instructions, discharge summaries and care plans. To the comments made about dynamics, there are elements that come in afterwards. That's exactly what we're working on is the dynamic nature of care plans and so that's under the standards piece and so the comments here fold very much into what that group is doing. There is a lot of very experienced nursing and medical folks, who are very, very familiar with what needs to go on in coordination of care. The concept of nothing about me: It's very easy on the Direct side to say send this whatever to this physician and then just copy it to the PHR or copy it to a patient. The same thing. It's very efficient. It's a very structured process and we would support that.

On the HIE piece I am very glad to hear that we got to a percentage of the elements. I would look at it if they 15 fax partners I'd say 20% of those were 6 point-to-points that a hospital sets up, so it is a percentage of their external medical trading area partners that are non-affiliated. They have to be non-affiliated. Yet, the comment was ... will do it. The problem is if the provider organization does not want to do it and the vendors sense that they will not put the robustness and this capability as if it was being used very heavily all of the time. There just won't be that effort. They're making tradeoffs.

Third point: ACO. I'd like to see an ACO Tiger Team, kind of when I was on HITSP where we went back when meaningful use came out and we looked at everything to make sure that everything was aligned and structured to support shared savings and what was going on. I know that just came out, but I think that's something that should be thought about. Finally, CCD versus CCR: Again, it's crazy that we're having to do that again, but as an organization like Dossia, we have been receiving those kinds of files for

years. They are incomplete. They weren't defined down to a level that is usable. It really needs to be worked on. I would not pick one or the other. I would leave it as both and then let's get to CCX. Let's get to the next generation that's informed by PCAST, informed by a couple of years of good work and let's do that for stage three. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. Hansen. We have Mark Segal on the telephone, please.

Mark Segal – GE Healthcare – Director Government & Industry Affairs
Yes. Thank you. This was really a great meeting today. I'd like to just suggest three items very quickly. First, just to really underscore the need for having some percentage of electronic summary exchange that's material, but achievable. I think per the discussion that you all had, it's very important to go beyond the test and to have real use cases, which will drive really the build out of HIE as both the verb and the noun. Secondly, on PCAST: Just to really underscore the recognition that the CCD document does provide the metatag data that PCAST called for without some of the other issues that were raised in the specific PCAST recommendations. The EHR association has given a detailed analysis on this to ONC and to the Policy Committee's PCAST Workgroup.

On the timing issue and sort of the need for the Policy Committee to act on this, I'd just like to really underscore that a signal from the Policy Committee and frankly, ONC and CMS, is really critical. As I'm sure you know, there are already public and widely disseminated recommendations that providers not actually attest in 2011 given the timing issue. The fundamental issue is that we won't know what the final requirements are until the CMS final rule is actually out. Even in the best of circumstances this will complicate vendor and provider planning for development and certification and deployment. You've got that gap, that small gap between the July rule and the October start for hospitals and also, we'll be facing new certification bodies. So in the best of circumstances, even limited new functionality will have specific new standards and certification criteria.

I'd also like and I thought the options were great to suggest evaluating, also adding, pushing out as it was done for this year this start for hospitals to December or to January rather in addition to the 90-day option. In terms of option four, that sounds very promising, but I'd certainly love to hear some more discussion about exactly how that would work out in terms of certification and what that would mean for vendors and providers. And just finally, again, encourage the discussion of really minimizing net new functionality, focus on increasing thresholds and I thought you had a great discussion today and Charlene did a terrific job of really identifying where there's already well defined functionality for the new addition so that the Policy Committee's work can be an effective signal to the market even before there are new certification criteria. Thank you very much for your time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Chantel, you have a comment?

Chantel Worzala – American Hospital Association – Sr. Associate Dir. of Policy
Good afternoon. Thank you so much for thinking and being so thoughtful about these very complex issues. I really appreciate the conversation. I did want to bring to your attention attachment B of the AHA's comment letter on stage two. It does include the results of a survey of 2,300 hospitals. That's one out of every four hospitals in the country. We did ask them very specifically about their current ability to perform each objective of meaningful use and whether or not their EHR is currently certified for that objective. You see a fair disparity by objective as to the share of hospitals that can do these things with certified EHR technologies. Those things that are tied to clinical care, whether it be the problem list or the medication list of the drug-drug allergy checks are pretty widely deployed by hospitals, but when you get down to those things where you're asking for a new standard or a way to share data that has not been used before, the numbers are very low.

What I just want to pause on for a moment and highlight are the three public health objectives, because those objectives require reporting to public health in the LOINC standard and 10% to 12% of hospitals can do each of those objectives today using certified EHR technology, a very low number. In those one

of the big issues is in fact the transformation to LOINC coding. This is very hard to do. It's very expensive and time consuming. It's not a one-time transformation, because it has to be kept up to date. In those public health objectives you have a set of your lab results that you're sharing in LOINC, so it's the reportable lab results or the biosurveillance data, so that's manageable, something you can sort of figure out how to get the mapping and move that forward, although frankly, ONC and CDC are concerned enough about this that they are partnering with us, with Surescripts and with CAP to help hospitals do this. So there is, by no means, a slam dunk, but the notion that you could just flip a switch and require hospitals to report all of their outgoing lab data in LOINC Is really not something that is achievable in the short-term. It's a very, very high bar. So I'm happy to make this appendix separately available to Judy. Maybe she can share it with folks, because it does give a very good snapshot of where we are or where we were in January 2011.

The other point that I wanted to make is as you go sort of objective-by-objective that's very important, but also we need to take a step back. What does it mean to put all of those together and add in that you need a certified EHR? Again, you must have a certified EHR against everything, even those things in a menu set that you choose not to do. You must possess. My tally in the request for comments was that for eligible hospitals you would go from the 19 required objectives in stage one to 32 if everything that was in the RFC is made a core objective. That's a 70% increase in the requirements on hospitals.

The last thing: Also in the data that I will share around, when we put all of those requirements together and looked at the share of hospitals that could today meet all of the meaningful use requirements, certification and functionality we got 1.6% of hospitals that could do this in January 2011. So there are data out there and again, that's one out of every four hospitals that responded to this survey. Again, I'll go ahead and make sure that gets shared in just the appendix form as opposed to the whole letter.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Chantel. We have one final comment from John Travis from Cerner.

John Travis – Cerner – Senior Director and Solution Strategist, Regulatory Compliance
Thank you. I'm not going to say anything that's really earth shattering, but I want to make one suggestion. I think it's helpful to kind of compare where we are back to where we were in a similar type of time frame for stage one and then roll forward if we go only that fast. I think most everybody involved in the effort would have reflected that things moved very rapidly in stage one from the initial statute to the final rule. The recommendations that were initially made from the formal process standpoint from the whole committee, occurred in about June 2009 if I recall right, and vendors really grabbed that and used it as a matter of basis for gap assessment and we had a certification program launched by September of 2010, so about a 15-month time interval.

If we compare to where we are now and we're talking about kind of assuming we're having committee recommendations in full and approved by about June of 2011 we're talking about a certification program launch potentially not until, if you go the same 15 months, very late in the summer of 2012; whereas, if we have the final, permanent program rule out indicating we could have a certification program launch by the start of 2012, which I'm not sure anybody really believes that or not. I just think a sobering fact to keep in front of you is that vendors are literally looking for something they can concretely take and judge for gap assessment and do a good faith effort of addressing those timely to pursuing certification and we're already marking time on that. We're trying to use what we see today, so a very good consolidated view of what the requirements are plus quality measures, kind of the clinical workflow objectives, security and privacy and functional, automated, calculated measures would be superb if we could have that kind of resource to work with as kind of an evolving state going along, knowing what we're expecting to go against and add into that the standards that would be nominated by ONC or by whatever body is going to carry that responsibility. We're really beginning to feel some pain here to look at what we have to do to get ready for stage two.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Great comments. Thank you to everyone for coming. See you next week, some of you.

Public Comment Received During the Meeting

1. Don't focus on PDF, searchable is the key.... OCR can be applied to a lot of input

2. Be careful with scanned copies or local copies of ADs in the EHR...they will quickly be out of date. Local copies may be dangerous.